www.discoveryasheville.com

2017-2018 Application for Enrollment
Discovery Montessori School

Child's Name: Preferred Name:
Child's Age: Date of Birth: Gender: ▫ Male ▫ Female
Anticipated Start Date:
Please select Program and Section. Circle your first choice of days:

Toddlers	**2 year olds**	**3-6 year olds**
For kids ages 12 months-2 years		
▫ 3 Full Day: M T W Th F	▫ 3 Full Day: M T W Th F	▫ 3 Full Day: M T W Th F
▫ 4 Full Day: M T W Th F	▫ 4 Full Day: M T W Th F	▫ 4 Full Day: M T W Th F
▫ 5 Full Day	▫ 5 Full Day	▫ 5 Full Day

***For the 3 and 4 day options we will try to accommodate your first choice, but may not be able to due to class size on a given day.**
Generally, what hours do you anticipate your child will be in attendance on a daily basis?

Parent or Guardian 1:
Name:
Address:
City/Zip:
Home Phone:
Cell Phone:
Work Phone:
Employer:
Occupation:
Email:

Parent or Guardian 2:
Name:
Address:
City/Zip:
Home Phone:
Cell Phone:
Work Phone:
Employer:
Occupation:
Email:

Child resides with: ▫ Both parents ▫ Mother ▫ Father ▫ Other:

_____

May we include your child's name and birthdate on our class roster, along with the names, phone numbers, and email addresses of the parents/guardians? (*Note: Class rosters are distributed via email and will not be published on our website.)* ▫ Yes ▫ No

CHILD INFORMATION

School/Group Experiences:

1. Has your child attended school or been in any group activities? If so, what schools or activities and for how long?

2. Has your child had any testing or other evaluation (i.e. developmental, behavioral, speech) that we should be aware of?

Social/Emotional:

1. Please describe your child's temperament and personal strengths.

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2. What do you consider your child's challenges?

Child Preferences:

1. What does your child love to do?

2. How does your child learn best?

Family:

1. Who usually cares for your child at home?

2. Names and ages of siblings:

3. Please describe any significant family events. (i.e. recent move, change in family structure)

Self-Care:

1. What can your child do by him/herself (i.e. dressing, eating, washing hands)?

2. What will your child need help with at school?

PARENT/GUARDIAN QUESTIONNAIRE

1. Do you have any concerns about your child's school experience?

2. What are you hoping this program will give your child?

3. Is there anything else you would like us to know about your child?

4. Do you have any interest in sharing your work, hobbies, or cultural traditions with your child's class? If yes, please let us know what you would be interested in sharing.

CONTACTS

Child will be released to the parents/guardians listed about. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name
Relationship Address Phone Number

_____
Name Relationship Address Ph

_____

Name Relationship Address Ph one Number

Name Relationship Address Ph one Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes ___ No ___

List any allergies and the symptoms and type of response required for allergic reactions:

_____

_____

_____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns:

_____

_____

_____

List any particular fears or unique behavior characteristics the child has:

_____

_____

List any types of medication taken for health care needs:

_____

Share any other information that has a direct bearing on assuring safe medical treatment for your child:

_____

_____

EMERGENCY MEDICAL CARE INFORMATION

Name of health care professional_____ Office Phone _____

Hospital preference if other than Mission _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian _____ Date _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Adminstrator _____ Date _____

Thank you for taking the time to complete this application to help acquaint us with your child. Please be sure to keep us informed of any changes in your child's life!

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