



# Dearcroft Montessori School

1167 Lakeshore Road East  
Oakville, Ontario L6J 1L3  
Tel: 905-844-2114 Fax: 905-844-3529



Email: [info@dearcroft-montessori.com](mailto:info@dearcroft-montessori.com) Web: [www.dearcroft-montessori.com](http://www.dearcroft-montessori.com)

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## WEST WIND JUNIOR HIGH APPLICATION

### STUDENT INFORMATION

Student: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Tel. No. \_\_\_\_\_

Birth Date: (day) \_\_\_\_\_ (month) \_\_\_\_\_ (year) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

PROGRAM (for Administration use only)      \_\_\_ Grade 7      \_\_\_ Grade 8

### PARENT/GUARDIAN INFORMATION

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Tel: \_\_\_\_\_

Home Tel: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Bus Tel: \_\_\_\_\_

Bus Tel: \_\_\_\_\_

Cell: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Name and Telephone (to call if parents cannot be reached, when child is ill and must be taken home): \_\_\_\_\_

Siblings (names and birth dates): \_\_\_\_\_

Transfers (Please provide the name of the Montessori School your child has attended, and the length of attendance): \_\_\_\_\_

Application for admission into the Junior High School program implies your two-year commitment to the duration of the program and your agreement to the terms stated in the schedule of fees.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Parent Signature

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\* In accordance with PIPEDA, your personal information will be used solely for communication purposes regarding Dearcroft Montessori School.



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Student Name: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Tel No: \_\_\_\_\_

Medical History (please list any health issues/concerns and communicable diseases):

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Please list the persons permitted access to your child at school, other than parents and/or guardians on application form. Persons you designate with permission to be released to their care from school:

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Please list special dietary restrictions/requirements in respect of diet, rest or physical activity:

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Please give written instructions for any medical treatment or drug or medication to be administered during school hours:

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