Dearcroft Montessori School

297 Oak Walk Drive | Oakville, ON | L6H 3R6
Tel: 905-617-2114 Email: info@dearcroftmontessoritrafalgarcrossing.com Web: www.dearcroft-montessori.com

APPLICATION FORM

Student: _____

Address: _____**City:** _____

Province: _____ **Postal Code:** _____ **Primary Tel. No.** _____

Birth Date: (day) _____**(month)** _____**(year)** _____ **Male** _____ **Female** _____

PROGRAM:

_____ **Toddler**	_____ **Casa**	**Junior Elementary**	**Extended Day Care**
_____ Half Day	_____ Half Day AM	_____ Level 1	_____ Before Care
_____ Full Day	_____ Half Day PM	_____ Level 2	_____ After Care
	_____ Full Day	_____ Level 3	

PARENT/GUARDIAN #1

Name: _____

Home Address:_____

Primary Tel:_____

Bus Address: _____

Bus Tel: _____

Cell: _____

Email: _____

PARENT/GUARDIAN #2

Name: _____

Home Address:_____

Primary Tel:_____

Bus Address: _____

Bus Tel: _____

Cell:_____

Email: _____

Emergency Name, Address &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 School your child has attended, and the length of attendance):
_____

Application for admission into the Montessori program implies your three-year commitment for the duration of each developmental level of the program and your agreement to the terms stated in the tuition schedule.

For Administration use only:
Date of Admission _____ ***Date of Discharge:*** _____

Medical Information:

Student Name: _____

Family Doctor:_____

Address: _____

Tel No: _____

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

Specialist Services/Therapy (please list any information pertaining to speech therapy, occupational therapy, assessments etc. for your child):

Please list the perons 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:

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

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

_____ _____

Parent /Guardian Signature **Parent/Guardian Signature**

Date: _____ **Date: _____**