

# Little Ivies Montessori

## Application for Admission

<b>Child's Last name:</b>		<b>First Name:</b>	
Date of Birth:		Place of Birth(City & State):	
Parent's Names:			
Address:		City:	Zip:
Home Phone:			
Mother's Work Phone:		Father's Work Phone:	
Mobile Phone:		E-Mail:	
With Whom Does the Child Live: Both Parents: <input type="checkbox"/> Mother: <input type="checkbox"/> Father: <input type="checkbox"/> Other: <input type="checkbox"/>			
<i>If Other, Please Specify Relationship:</i>			
Name:		Phone:	
Address:			
Guarantor: (Person Responsible For Registration And Fees):			
Mother's Employer:			
Father's Employer:			
List who else is authorized to pick your child from The Academy – (will have to show their picture ID, so please provide their Driver License number). Include spouse if authorized to pick when the child does not live with both parents.			
Name Phone No. & relationship:			
Name Phone No. & relationship:			
PLEASE PROVIDE IMMUNIZATION RECORDS. IF THE CHILD IS 4 YEARS OR OLDER WE ALSO REQUIRE HEARING AND VISION TEST RESULT REPORTS.			
<u>Transportation:</u> I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give <input type="checkbox"/> consent for my child to be transported by facility's staff on field trips <input type="checkbox"/> to the library or other nearby extra-curricular activities <input type="checkbox"/> to and from school <input type="checkbox"/>			
<u>Water Activities:</u> I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give <input type="checkbox"/> my consent for my child to participate in water sports provided by the facility: splashing or wading pools <input type="checkbox"/> swimming pools <input type="checkbox"/>			
<u>School Age Children:</u> My child attends the following school and his/her immunization records are on file at that school and immunizations and TB test are current. _____			
Please consider my child for admission. I understand there is an annual registration fee. <u>Please read the Fee Schedule, Terms, and Conditions.</u>			
<i>I have read and agree to the Fee Schedule &amp; T/C's</i>			
<b>Parent (Guardian): Signature</b> _____ <b>Date:</b> _____ <b>Driver License No.</b> _____			
<b>For office use only:</b> Class: _____ Start Date: _____ Drop Date: _____ Fee(\$) _____ Weekly _____ Monthly			
Days in Care: M T W TH F OR (M-F) Hours in Care: Circle one (7 to 6) (7 to 4) (9-4) (9-6)			
Comments: _____			

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## Emergency Authorization

Child's Last Name:

First Name:

Parents' Names:

Address:

Guardians Name (If Different From Parents):

Home Phone Number:

Mother's Work Number:

Mobile Phone:

Father's Work Number:

Mobile Phone:

If a parent (guardian) cannot be reached in case of emergency, the Academy has permission to contact the following persons in the order listed:

Name:

Phone:

Address

Name:

Phone:

Address

Emergency contacts must be reliable persons, who could make themselves available immediately and who have transportation during your child's attendance hours. They must be people whom your child knows well, and who can and are ready to pick your child from school and provide care.

In case the services of a physician are required before either a parent (guardian) or one of the emergency contacts can be reached, the following doctor may give my child any treatment necessary. I (the parent or guardian) assume responsibility for payment of such professional service.

Doctor:

Phone:

Address:

Is Your Child Allergic To Any Medication:

Pls. Specify:

Is Your Child Allergic To Any Other Substance:

In case of an emergency, when a parent, guardian, emergency contact, or the above physician cannot be reached, the Academy has my permission to take my child by car, van or ambulance to a hospital. The hospital personnel have my permission to treat the child.

\_\_\_\_\_

Signature of Parent (or Guardian)

\_\_\_\_\_

Date

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Immunization Record											
Name of Child:							Date of Birth:				
Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
DTP											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
TB TEST (if required)		<input type="checkbox"/> Positive			<input type="checkbox"/> Negative			Date:			
Signature or stamp of a physician or public health personnel verifying immunization information above.											
						Signature			Date		
Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about _____ and does not need varicella vaccine.											
						Parent's signature			Date		
<input type="checkbox"/> I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.											
<b>For additional information regarding immunizations contact the Department of State Health Services at <a href="http://www.dshs.state.tx.us/immunize/public.shtm">www.dshs.state.tx.us/immunize/public.shtm</a></b>											

**ADMISSION REQUIREMENT:** If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission. Please check only one option:

**HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he / she is to take part in the day care program.

A signed and dated copy of a health care professional's statement is at attached

Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission; I will obtain a health care professional's signed statement and will submit it to the child-care operation.

**VISION:** R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ O PASS O FAIL

**HEARING:** 1000HZ : R \_\_\_\_\_ L \_\_\_\_\_ 2000HZ: R \_\_\_\_\_ L \_\_\_\_\_ 4000HZ:: R \_\_\_\_\_ L: \_\_\_\_\_

PASS  FAIL

Name and Address of health care professional:

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