ALPHA MONTESSORI SCHOOL
1625 SOUTH MANNHEIM ROAD
WESTCHESTER, ILLINOIS 60154
(708) 865-0099

ENROLLMENT FORM

Date Enrolled: _______________

Date Discharged: ______________

Child's Name: ____

Child's Birthday: __________________ Gender: ___________

Address: ____

City: ____

Zip Code: _____________________________

CONTACT INFORMATION:

Name: _________________________________	Name: _________________________________
Relation to Child: ________________________	Relation to Child: _________________________
Home Address: __________________________	Home Address: __________________________ (If different)
Home Phone: __________________________	Home Phone: _____________________________
Place of Employment: ___________________	Place of Employment: ______________________
Work Address: __________________________	Work Address: ____________________________
___________________________	_______________________________
Work Phone: ____________________________	Work Phone: _____________________________
Working Hours: __________________________	Work Hours: ____________________________

OTHER PERSONS TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED:

Name: ______________________________	Name: ___________________________________
Relation to Child: _____________________	Relation to Child: __________________________
Phone: _______________________________	Phone: ___________________________________

Parent Signature: ____

MEDICAL INFORMATION

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED:
NAME OF PHYSICIAN: ____

PHONE OF PHYSICIAN: ________________________

ADDRESS OF PHYSICIAN: _____________________________________

HOSPITAL OR CLINIC THAT THE CHILD ATTENDS: ____

PHONE OF THE HOSPITAL: _______________________________

Has your child had or been diagnosed with the following?

(Please circle)

Diabetes	**Chicken Pox**	**Measles**
Convulsions	**Lice**	**Mumps**
Fainting Spells	**Heart Disease**	**Polio**
Frequent cough	**Hepatitis**	**Ringworm**
Frequent Ear Infections	**German Measles**	**Scarlet Fever**
Frequent Sore throat	**Skin problems (Sun Allergy?)**	
Urinary Problem	**Tuberculosis**	
Whooping Cough		

OTHER MEDICAL PROBLEM____________________________________

PHYSICAL HANDICAPS____

Parent Signature:____________________________

INFORMATION OF THE CHILD

1. **Does your child have any speech, hearing, or visual problems?**
   ____
   ____
2. **Does the child regularly take any medicine? _____________**
   If so, what kind and directions____

   Would there be any restrictions to play or activities? ____

   Has your child ever been in a child care setting before? ___________________
3. **What type? (Center, Family Daycare, grandma care, etc.)**
   ____
4. **Was it a positive or negative experience?**
   ____
5. **How does your child feel about daycare and being left by their parents?**
   ____
   ____
6. **Are there any recent emotionally stressful situations or fears the child has been exposed to such as a death in the family, divorce, new sibling, etc?**
   ____
   ____
7. **Are there any food restrictions or allergies?**
   ____
8. **What is your child's favorite food or foods?**
   ____
9. **What food or foods does your child dislike?____**
10. **Does the child take a nap? ________________**

    Time: _______________ Duration: ____________
11. **Can your child be relied upon to indicate bathroom time? _____________________**
12. **What language(s) are spoken at Home? ____________________________________**
13. **What are child's favorite activities, toys, books, or games?**
    ____
    ____
14. **Are there any other comments or information you would like to let us know about?**

____

____

Parent Signature: _____________________________________

EMERGENCY MEDICAL CARE CONSENT

This authorizes Alpha Montessori School to secure EMERGENCY medical care for my/our child when we cannot be immediately reached at the time of emergency. I/We will be responsible for the emergency medical charges upon receipt of the statement. ____ is the preferred doctor/clinic/hospital.

Date: _______________

Signature of Parent/Guardian: __________________________

Relationship to Child: __________________________________

Date: _____________________

Signature of Parent/Guardian: _____________________________

Relationship to Child: ___________________________________

ADMINISTER PRESCRIPTION MEDICINE CONSENT

I/we authorize Alpha Montessori School to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date: ________________

Signature of Parent/Guardian: ______________________________

Relationship to child: ______________________________________

Date: _________________________

Signature of Parent/Guardian: _________________________________

Relationship to child: ____

ADMINISTER OVER-THE-COUNTER MEDICINE

I/We authorize Alpha Montessori School to administer over-the-counter medicine to my/our child as specified in written instructions.

Date: ____________________

Signature of parent/guardian: _______________________________

Relationship to child: ______________________________________

Date: __________________________

Signature of parent/Guardian: _______________________________

Relationship to child: ______________________________________

AUTHORIED CONSENT TO PICK UP THE CHILD

THE CHILD IS NOT ALLOWED TO LEAVE SCHOOL WITH ANYONE ELSE WITHOUT WRITTEN PERMISSION OF THE PARENTS.

Primary Guardians who will pick up the child:

NAMES	RELATIONSHIP	PHONE
1.__________________________	___________________________	_____________________
2.___________________________	____________________________	____________________

CONTINGENCY LIST

Name of persons other than the guardians authorized to pick your child.

NAMES	RELATIONSHIP	PHONE	CONDITION
1.______________________________	__________________	________________	______________________________
2______________________________	__________________	__________________	______________________________
3.______________________________	__________________	__________________	______________________________

Plans of Service: **Circle one**

- **PLAN A HALF DAY** **8:00 A.M. TO 12:00 P.M.**
- **PLAN B FULL DAY** **8:00 A.M. TO 3:00 P.M.**
- **PLAN C EXTENED DAY** **8:00 A.M. TO 5:00 P.M.**

Other Hours:____
____

Signature of the Parent/Guardian: ________________________

Relationship to child: ______________________________

Date: __________

Signature of the Parent/Guardian: ________________________

Relationship to child: _________________

Date: ____________

TRIPS, EXCURSIONS AND PUBLIC PARK FACILITIES

Name of Child: ____

I/We authorize Alpha Montessori School to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/We also authorize the child to ride as a passenger in the vehicle owned/ or leased by the above-named person(s). I/We understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date: ______________________

Signature of the Parent/Guardian: _______________________________

Relationship to child: ______________________________

Date: ______________________

Signature of the Parent/Guardian: _____________________________

Relationship to child: _________________________