

Woodland Montessori School

Barrie, ON

info@woodlandmontessori.ca

Please check age group:

Toddler (18 months – 2 1/2 years old) Casa (2 ½ years – 6 years old)

5 Days/Week 4 Days/Week 3 Days/Week 2 Days/Week

Please circle days your child will be attending: M T W TH F

Before School Program After School Program Before and After School Program

STUDENT INFORMATION

Surname, Given Name _____ Date of Birth _____

Home Address _____ Home Telephone _____

Language(s) spoken at home

People living in household other than parents and siblings

Siblings (Names, Ages)

PARENT INFORMATION

MOTHER

Surname, Given Name _____

Home Address (if different than above)

Email: _____

Home Phone Number: _____

Cell Phone Number: _____

Business Phone Number: _____

Business Name and Address:

FATHER

Surname, Given Name _____

Home Address (if different than above)

Email: _____

Home Phone Number: _____

Cell Phone Number: _____

Business Phone Number: _____

Business Name and Address:

EMERGENCY INFORMATION

Please provide information about the person(s) to be contacted if parents are unavailable.

Name _____ Relationship to Child _____

Phone Number _____ Cell Phone _____

Address _____

Name _____ Relationship to Child _____

Phone Number _____ Cell Phone _____

Address _____

If I am/we are not available in case of an emergency, I grant permission for Woodland Montessori School, to select a physician to treat my child.

Child's Name _____ Date _____

Signature of Parent/Guardian _____

PICK UP INFORMATION

The following people are permitted to pick up my child.

Name _____ Relationship to Child _____

Phone Number _____ Cell Phone _____

Name _____ Relationship to Child _____

Phone Number _____ Cell Phone _____

STUDENT MEDICAL INFORMATION

Child's Family Physician _____ Phone Number _____

Address _____

Allergies

Please list your child's allergies (if applicable) _____

Are these allergies (circle one): mild moderate severe anaphylactic (life threatening)?

Please explain _____

Medical Concerns

Does your child have any medical conditions that we need to be aware of? Please explain. In general, what are your child's symptoms indicative of ill health?

Please list child's history of communicable diseases (chicken pox, measles, tetanus, etc.)

My child is immunized: _____ YES _____ NO

If child is not immunized, I have included a statement as to why my child should not be immunized.

_____ YES _____ NO

please submit a photocopy of your child's Immunization with application

Signature of Parent

Date

Date of Admission: _____ (day, month, year)

Date of Discharge: _____ (day, month, year)

