

Arrival and Departures

Each Child will have a designated arrival and departure time. Prompt arrival and departure is crucial to the flow of the Montessori environment. Registering your child for a specific time is your commitment to assuring arrival/departure promptness. The following time slots are available for you to choose from. Space for extended care is limited. The crossed off time slots are full. Please choose a time that is open. Thank you.

Arrival time of:
(Choose one)

- 7:00 a.m.
- 7:10 a.m.
- 7:30 a.m.
- 7: 45 a.m.
- 8:00 a.m.
- 8:15 a.m.
- 8:30 a.m.
- 8:50 a.m.

Departure time of:
(Choose one)

- 11:30 a.m. (part-time only)
- 2:30 p.m.
- 3:00 p.m.
- 3:30 p.m.
- 4:00 p.m.
- 4:15 p.m.
- 4:30 p.m.
- 4:45 p.m.
- 5:00 p.m.
- 5:10 p.m.
- 5:20 p.m.
- 5:30 p.m.
- 5:45 p.m.

I understand the importance of arrival and departure promptness and will follow the times I have chosen for my child to arrive and depart from school. If I am unable to pick up my child at my departure time for a special occasion I will notify the teacher **prior** to the date, otherwise, I understand that I will be charged \$20.00 for every fifteen minutes late after my chosen departure time.

X _____
Parent/ Guardian Signature

X _____
Parent/ Guardian Signature

APPLICATION PROCEDURE

Please submit the Application, registration fee, and deposit to Discovery Montessori Academy. The Director will contact you regarding acceptance. Mail to:

Discovery Montessori Academy
804 7th Ave South
Princeton, MN 55371

Preschool-Kindergarten registration fee: \$40.00
(Annual fee & non-refundable)

Due _____ **Paid** _____ **Date** _____

Elementary Registration Fee: \$100.00
(Annual fee & non-refundable)

Due _____ **Paid** _____ **Date** _____

All Students - Deposit (one week, non-refundable):

Due _____ **Paid** _____ **Date** _____

Discovery Montessori admits students of any race, color, national or ethnic origin to all rights, privileges, programs, and activities accorded or made available to students at the school. It does not discriminate on the basis of race color, sex, national and ethnic origin in administration of its educational policies and admission policies. Discovery Montessori considers the records of all individual students to be confidential information available to a child's parents or guardians upon request.

*****OFFICE USE ONLY*****

Date of enrollment _____ **First Day of Class** _____

Teachers _____

Date of withdrawal _____ **years with DMS:** _____

Reason for Leaving: _____ **Forwarding Address:** _____



Preschool-Kindergarten Weekly Tuition Payment Contract

Name of Student: _____

Start Date: _____

Welcome! Discovery Montessori Academy operates primarily on the tuition fees from each family. Please read over this contract carefully so the policies stated are completely understood. We want you to be happy with the school you have selected and we want to prevent misunderstandings.

Registration Fee: I agree to pay a \$40.00 non-refundable registration fee, due with the Enrollment Forms. This fee is not deductible from the tuition fees.

Tuition Payments: I agree to pay tuition of \$_____ per week per child. I understand that payment of \$_____ is due by the first school day (Monday for fulltime, Tuesday for part-time) morning for the following week's service. I may pay in advance if I choose. Checks must be made payable to Discovery Montessori Academy. Checks may be mailed to the administrative address above or may be put in the locked tuition payment box.

Late Payment Charge: I understand that tuition that is late will incur a fee of \$5.00 per day. It is crucial that my payment is received on time. Past due tuition may affect my child's enrollment status. My child will not be able to continue the next school session nor will records be transferred. Past due tuition will incur a 10% increase for each month late.

Withdrawal Policy: I will notify Discovery Montessori Academy with a written notice one month in advance of withdrawal from the program. I am held responsible for tuition for one full month after notice is received to allow the school time to fill vacancy. Failure to comply will result in legal expense including a potential counter claim expense.

Absence: If my child is absent (for example: illness or vacation) I understand I will still be required to pay the fee for the day(s). I understand my child's place in the program is still reserved whether he/she is there or not. I understand that tuition is due even when the school is closed for the holiday breaks.

Late Pickups: I agree that if I am more than 10 minutes late to pick up my child I will pay a fee of \$20.00 for every 15 minutes I am late. This will be paid immediately to staff on site.

Signature of Parent/Guardian

Date

Discovery Montessori Academy Authorized Signature

Date



804 7th Ave South Princeton, MN 55371

Preschool-Kindergarten Monthly Tuition Payment Contract

Name of Student: _____

Start Date: _____

Welcome! Discovery Montessori Academy operates primarily on the tuition fees from each family. Please read over this contract carefully so the policies stated are completely understood. We want you to be happy with the school you have selected and we want to prevent misunderstandings.

Registration Fee: I agree to pay a \$40.00 non-refundable registration fee, due with the Enrollment Forms. This fee is not deductible from the tuition fees.

Tuition Payments: I agree to pay tuition of \$_____ per month per child. I understand that payment of \$_____ is due by the first school day of the month. I may pay in advance if I choose. Checks must be made payable to Discovery Montessori Academy. Checks may be mailed to the administrative address above or may be put in the locked tuition payment box.

Late Payment Charge: I understand that tuition that is late will incur a fee of \$5.00 per day. It is crucial that my payment is received on time. Past due tuition may affect my child's enrollment status. My child will not be able to continue the next school session nor will records be transferred. Past due tuition will incur a 10% increase for each month late.

Withdrawal Policy: I will notify Discovery Montessori Academy with a written notice one month in advance of withdrawal from the program. I am held responsible for tuition for one full month after notice is received to allow the school time to fill vacancy. Failure to comply will result in legal expense including a potential counter claim expense.

Absence: If my child is absent (for example: illness or vacation) I understand I will still be required to pay the fee for the day(s). I understand my child's place in the program is still reserved whether he/she is there or not. I understand that tuition is due even when the school is closed for the holiday breaks.

Late Pickups: I agree that if I am more than 10 minutes late to pick up my child I will pay a fee of \$20.00 for every 15 minutes I am late. This will be paid immediately to staff on site.

Signature of Parent/Guardian

Date

Discovery Montessori Academy Authorized Signature

Date



804 7th Ave South Princeton, MN 55371

Elementary Tuition Payment Contract

Name of Student: _____

Start Date: _____

Welcome! Discovery Montessori Academy operates primarily on the tuition fees from each family. Please read over this contract carefully so the policies stated are completely understood. We want you to be happy with the school you have selected and we want to prevent misunderstandings.

Registration Fee: I agree to pay a \$100.00 non-refundable registration fee, due with the Enrollment Forms. This fee is not deductible from the tuition fees.

Tuition Payments: I agree to pay tuition of \$_____ per month per child. I understand that payment of \$_____ is due by the first school day of the month. I may pay in advance if I choose. Checks must be made payable to Discovery Montessori Academy. Checks may be mailed to the administrative address above or may be put in the locked tuition payment box.

Late Payment Charge: I understand that tuition that is late will incur a fee of \$5.00 per day. It is crucial that my payment is received on time. Past due tuition may affect my child's enrollment status. My child will not be able to continue the next school session nor will records be transferred. Past due tuition will incur a 10% increase for each month late.

Withdrawal Policy: I will notify Discovery Montessori Academy with a written notice one month in advance of withdrawal from the program. I am held responsible for tuition for one full month after notice is received to allow the school time to fill vacancy. Failure to comply will result in legal expense including a potential counter claim expense.

Absence: If my child is absent (for example: illness or vacation) I understand I will still be required to pay the fee for the day(s). I understand my child's place in the program is still reserved whether he/she is there or not. I understand that tuition is due even when the school is closed for the holiday breaks.

Late Pickups: I agree that if I am more than 10 minutes late to pick up my child I will pay a fee of \$20.00 for every 15 minutes I am late. This will be paid immediately to staff on site.

Signature of Parent/Guardian

Date

Discovery Montessori Academy Authorized Signature

Date



Parental Consent Statements

For each statement, INITIAL the line next to the statement if you give consent. If you do not give consent, circle "No" and provide comment. DMA is Discovery Montessori Academy.

___ I give DMA staff member permission to give basic first aid to my child.
No. Comment: _____

___ I give permission for the DMA staff to act in an emergency situation when I am unable to be reached or when medically necessary.
No. Comment: _____

___ I give DMA and all its staff/volunteers permission to transport my child during a school bus or walking field trip. I understand I will be notified in advanced on each individual field trip and transportation agreements.
No. Comment: _____

___ I give DMA staff permission to photograph/video tape my child (during normal activities of the day, during special events and on field trips) for display purposes in classroom and for the school year book.
No. Comment: _____

___ Photo/Video Release for public for educational purposes:
DMA has my permission to use my child's photograph publically to promote the school. I understand that the images may be used on the school's website and on the school's Facebook to help other families learn and/or share about their experience at DMA. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.
No. Comment: _____

Parent/Guardian's signature: _____ Date _____

Parent/Guardian's Name: _____

Child's Name: _____

Phone Number: _____



Trial Period & Family Handbook Agreement

Student Name: _____ First Day of School _____

Trial Period

The Montessori Method is a unique approach used when educating a child. It is so unique that we like to start the child on a 30- day trial period to see how the environment meets the child's needs. We split the 30-day period into week by week segments. During the first week there will be notes or conferencing about the transition from the teacher. The teacher will use his/her best discretion to determine if the environment is working. If he/she feels confident she may ask your child to continue for the next week and son on. Further enrollment may be discussed when the teacher feels it is appropriate.

I (parent/guardian) understand the importance of the trial period. I understand that this environment may or may not work for my child and that if the teacher feels that this fit is not right for my child Discovery Montessori Academy has no obligation to enroll my child into the program.

Family Handbook

I have read all the policies contained in the Family Handbook (found online at DiscoveryMontessoriAcademyMN.com) and agree to follow them to the best of my abilities. I also understand failure to follow the school's policies may result in termination of my child's enrollment at Discovery Montessori Academy.

I have read both the Trial period policy and the Family Handbook policy and agree to the statements above.

Parent/Guardian Signature

Date

EMERGENCY INFORMATION

Child's Name: _____ **Gender (M or F):** _____ **Birthdate:** _____
Grade: _____ **Today's Date** _____
Home Address _____

PARENT(S) AND/OR LEGAL GUARDIAN:

Name: _____ **Place of Employment:** _____
Home Phone: _____ **Work Phone:** _____ **Ext.** _____

Name: _____ **Place of Employment** _____
Home Phone: _____ **Work Phone:** _____ **Ext.** _____

MEDICAL MATTERS/EMERGENCY MEDICAL TREATMENT:

I hereby warrant that, to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. In the event of an emergency, I hereby give my permission for the school staff to initiate emergency treatment and to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital doctor. In the event of a medical emergency, if you are unable to reach me at the above phone numbers, I give the following listed people my permission to transport my child and make medical decisions in my absence.

Name/Relationship: _____ **Daytime Phone:** _____
Address: _____

Name/Relationship: _____ **Daytime Phone:** _____
Address: _____

Name/Relationship: _____ **Daytime Phone:** _____
Address: _____

Family Doctor: _____ **Clinic:** _____ **Phone:** _____
Family Dentist: _____ **Clinic:** _____ **Phone:** _____
Family Health Plan Carrier: _____
Policy #: _____ **Phone:** _____

Does your child have any allergies to drugs or foods? _____

Does your child take any special medication? _____

Are there any health concerns/conditions (ex. Asthma, diabetes, vision)? _____

Parent/Guardian Signature _____ **Date** _____
.....

PLEASE COMPLETE THE FOLLOWING INFORMATION IF YOU CHILD ATTENDS DAYCARE:

Daycare
Provider: _____ **Phone:** _____
Address: _____

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____

Birth Date _____

ADDRESS _____

Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

What is the status of the child's...

Vision _____

Hearing _____

Speech _____

Please list below the important health problems

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program _____

Phone _____

Signature of Health Source _____

Address _____

Date _____

Consent for Release of Health Information

In Accordance With 9503.0125

The information contained in the child's record is collected to assist the license holder in providing appropriate care for the child. It is available to the child, the child's parent or guardian, the child's legal representative, employees of the license holder and the Commissioner of the Minnesota Department of Human Services.

With this release, I permit the health consultant of the license holder to review health and medical information contained in the child's record in order to identify specific health/medical needs of the child and to recommend the program plans to assist the license holder to meet these health/medical needs.

Signature of Parent/Guardian

Date

Child's Full Name _____

Authorized Pick-ups

I authorize the following people to pick up my child from school when I am unable to do so. I understand that the following people will present a **picture identification card** to verify authorization. I understand that if the proper identification is not shown, my child will remain in care of the staff at school until proper identification is verified. I will notify the school ahead of time of special pick-ups if the situation allows me to do so.

Name (first and last): _____

Relationship to family: _____

Address: _____

Phone Number: _____

Name (first and last): _____

Relationship to family: _____

Address: _____

Phone Number: _____

Name (first and last): _____

Relationship to family: _____

Address: _____

Phone Number: _____

Name (first and last): _____

Relationship to family: _____

Address: _____

Phone Number: _____

Signature of Parent/Guardian

Date

Immunization Form

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Name _____

Birthdate _____

Immunizations required for child care, early childhood programs, and school.

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

Vaccine

Hepatitis B	<input type="text"/>				
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)	<input type="text"/>				
<i>Haemophilus influenzae</i> type b (Hib)	<input type="text"/>				
Pneumococcal (PCV)	<input type="text"/>				
Polio	<input type="text"/>				
Measles, Mumps, Rubella (MMR)	<input type="text"/>				
Chickenpox (varicella)	<input type="text"/>				
Hepatitis A	<input type="text"/>				
Tetanus, Diphtheria, Pertussis (Tdap)	<input type="text"/>				
Meningococcal (MCV4)	<input type="text"/>				

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

- Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
 - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
 - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
- Sign or get the signatures needed for the back of this form.
 - Document medical and/or non-medical exemptions in section 1.
 - Verify history of chickenpox (varicella) disease in section 2.
 - Provide consent to share immunization information (optional) in section 3.

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).

Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
<i>Haemophilus influenzae</i> type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _____ (name of parent or guardian)

Notary Signature: _____

Notary Stamp
STATE OF MINNESOTA, COUNTY OF _____

Signature: _____ Date: _____
(of health care practitioner*)

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

* Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

- 3. Consent to share immunization information:** This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:
 - Provide easier access for you and your school to check immunization records, such as at school entry each year.
 - Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.
 - Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.
 - I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:
- Signature: _____ Date: _____
(of parent/guardian)

MASK PREFERENCE FORM

This form only needs to be completed if you have mask wearing preference. If you do not fill out this form, your child will not be asked to wear a mask.

Because of the uniqueness of our blended childcare program, our state licensor has deemed that our program is exempt from the current mask laws declared by Gov. Walz July 25, 2020. This allows each parent to mask their child at their own discretion. **At this point as a childcare center/distance learning proctor we do not require the children to wear masks.**

In addition, this also means that our staff members and teachers are not required to wear masks or face shield at this point when teaching in their classrooms. They may choose to wear masks or face shields at their own discretion. We do have select times when staff are required to wear masks throughout the day.

If you would like to have your child wear a mask, please provide a new one (clean one) daily.

I would like my child _____ (child's full name) to wear a mask during their attendance at Discovery Montessori Academy. I will provide a clean mask daily for my child. I understand that my child will NOT wear one during the follow times:

- Exercise or large movement times
- During outside time
- During snack/lunch time or beverage drinking time
- While they sleep

Parents or Guardians full name and signature

Date

For future use only:

I wish to expel my face mask request starting on this date: _____.

Parents or Guardians full name and signature

Date



The Family Handbook and the **New Family Handbook Policies/COVID-19 Plan Updates** are now posted online and available per request. Please read over the policies carefully and address any questions or concerns to the Director of Education.

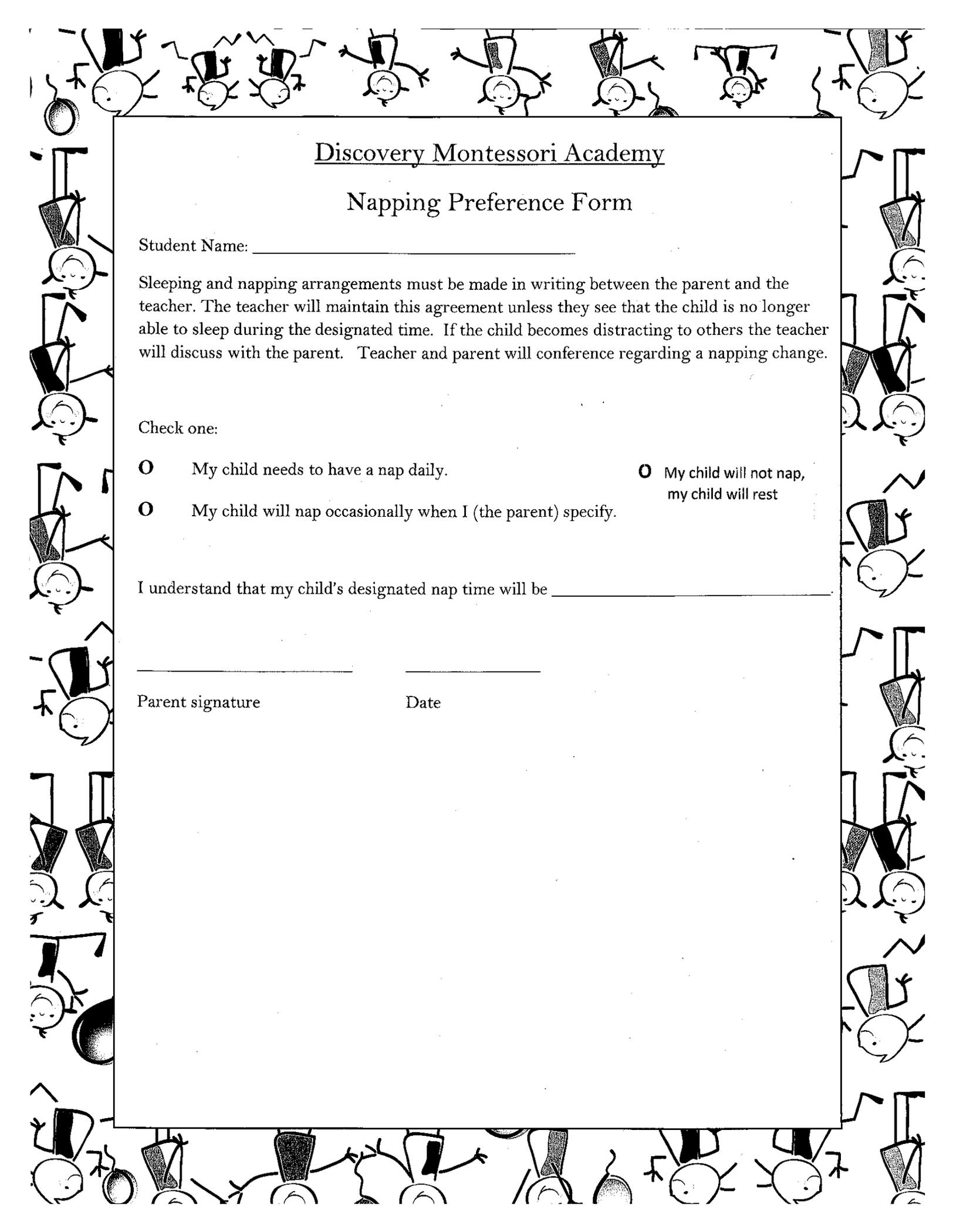
I have read all the policies contained in the Family Handbook and in the New Family Handbook Policies/COVID-19 Plan Update (found online at DiscoveryMontessoriAcademyMN.com) and agree to follow them to the best of my abilities. I also understand failure to follow the school's policies may result in termination of my child's enrollment at Discovery Montessori Academy.

I understand that my child may not attend school at Discovery Montessori Academy until I agree to the policy terms.

Student(s) Name: _____

Parent/Guardian Name Print and Signature

Date



Discovery Montessori Academy

Napping Preference Form

Student Name: _____

Sleeping and napping arrangements must be made in writing between the parent and the teacher. The teacher will maintain this agreement unless they see that the child is no longer able to sleep during the designated time. If the child becomes distracting to others the teacher will discuss with the parent. Teacher and parent will conference regarding a napping change.

Check one:

- My child needs to have a nap daily.
- My child will not nap, my child will rest
- My child will nap occasionally when I (the parent) specify.

I understand that my child's designated nap time will be _____

Parent signature

Date