



Dear Parents:

**Please remember to bring the following items to school on your child's first day:**

**FROM HOME:**

- Registration Packet, completed and signed (due two business days prior to start date);
- 2 Full changes of clothes, including underwear and socks (labeled and placed in a plastic zip-lock bag);
- Water bottle filled with water;
- Drawstring bag with all of your child's belongings;
  
- Fitted crib sheet and a blanket;
- Children who are not potty trained will need diapers, wipes, and optional diaper cream with a #5 Form from the front office;
- Any other supplies your teacher requests.

**FROM THE DOCTOR'S OFFICE (within 2 weeks of registration)**

- Original Blue Immunization form (#680) signed and stamped by the doctor's office;
- Original Yellow Physical Health Exam Form (#3030) signed and stamped by the doctor's office.

**Please label EVERY ITEM with your child's name using a permanent marker!  
Refer to your Parent Handbook for additional information.**

Thank you,

**Acreage Montessori Academy**

Classroom \_\_\_\_\_  
Registration \_\_\_\_\_

# 1

## SOCIAL SERVICES DIVISION CHILD CARE PROGRAM CHILD ENROLLMENT INFORMATION

\_\_\_\_\_  
PASSWORD

Preferred Name \_\_\_\_\_ Child Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Tuition Program Time: \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Sex M F D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME

HOME ADDRESS

HOME PHONE

Mother \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Father \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Guardian \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Mother Cell Phone ( ) \_\_\_\_\_ Father Cell Phone ( ) \_\_\_\_\_

Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

Mother \_\_\_\_\_ ( ) \_\_\_\_\_  
Place of employment Occupation Phone/extension

Father \_\_\_\_\_ ( ) \_\_\_\_\_  
Place of Employment Occupation Phone/extension

Parents Marital Status: S M D or W

Child's Physician \_\_\_\_\_

Address of Physician \_\_\_\_\_ Phone \_\_\_\_\_

May the center call another physician if unable to contact the above? \_\_\_\_\_

Persons permitted to remove child: Mother: Yes or No Father: Yes or No

In case of an emergency or illness, other persons to be notified and permitted to remove child from center: (Must be 18 years of age to remove child from center)

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of person enrolling child: \_\_\_\_\_

## EMERGENCY INFORMATION

Name of Child: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name of Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

### Persons authorized to act for parents in case of emergency:

First Choice:

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_

Second Choice:

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_

### **Medical History:**

Measles: Yes or No

Mumps: Yes or No

Chicken Pox: Yes or No

Convulsions: \_\_\_\_\_

Allergies (food, medicine, etc.): \_\_\_\_\_

Any evidence of hearing difficulty? Yes or No      Explain: \_\_\_\_\_

Any evidence of visual difficulty? Yes or No      Explain: \_\_\_\_\_

Birthmark: Yes or No      Explain: \_\_\_\_\_

Speech disabilities? Yes or No      Explain: \_\_\_\_\_

Hospitalizations? Yes or No      Explain: \_\_\_\_\_

Operations? Yes or No      Explain: \_\_\_\_\_

Other illnesses? \_\_\_\_\_

Does your child have any physical handicaps or conditions which might affect his/her schooling? \_\_\_\_\_

Please describe: \_\_\_\_\_

Briefly describe your child as a person: likes, dislikes, favorite past times, toys, friends, toilet habits, napping needs, etc. In essence, please include anything that will help us understand your child and help him/her grow:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Classroom:** \_\_\_\_\_

## **Individual Information**

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent's Names: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies, food restrictions, or medical problems?

\_\_\_\_\_  
\_\_\_\_\_

What are your child's favorite foods?

\_\_\_\_\_

What are your child's favorite activities?

\_\_\_\_\_

Is your child: shy \_\_\_ outgoing \_\_\_ aggressive \_\_\_ cry easily \_\_\_ easily frustrated \_\_\_

Are there any areas of difficulty that you would like your child to work on?

\_\_\_\_\_

\*\*Please use the back of this sheet to list any additional information you feel would be helpful in caring for your child



## **PASSWORD FORM (Applies to all Students)**

To ensure your child's safety at dismissal, ACREAGE MONTESSORI ACADEMY, in compliance with DCF regulation, has instituted a "password program". This program is designed to ensure that an authorized person is picking up your child.

Please choose a word that will be easy for you to remember. This password should only be given to those whom you authorize to pick up your child. Please fill in the form below and return it to the office as soon as possible.

CHILD'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

PASSWORD \_\_\_\_\_

PARENT'S SIGNATURE \_\_\_\_\_

PARENT'S DRIVERS LICENSE NUMBER \_\_\_\_\_

## **AFTER SCHOOL CARE PERMISSION FORM**

I give Acreage Montessori Academy permission to pick up my child \_\_\_\_\_

at \_\_\_\_\_ Elementary School.

Parent Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

## **FIELD TRIP PERMISSION SLIP**

I give permission for my child \_\_\_\_\_ to go on all field trips.

I understand that I must notify ACREAGE MONTESSORI ACADEMY in writing if I do not want my child to go on a certain trip.

Parent Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_



## Authorization for Emergency Treatment

Today's Date: \_\_\_\_\_

To whom it may concern,

I hereby give my consent to \_\_\_\_\_ (name of Hospital)  
to administer necessary treatment to my child, \_\_\_\_\_ (name of child) in the  
event of an emergency at which time I cannot be reached. I give consent to transport by  
ambulance if the situation warrants it.

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies of Child: \_\_\_\_\_

Date of last DPT or Tetanus: \_\_\_\_\_

Insurance Company Covering Child: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

By \_\_\_\_\_ (name of Person Acknowledged).

My Commission Expires:

\_\_\_\_\_  
Signature of Notary Public, State of Florida

Personally Known

Produced Identification

Type: \_\_\_\_\_

# : \_\_\_\_\_



## **PERMISSION TO PHOTOGRAPH**

Today's Date \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Photographs and videos of the children are taken on different occasions. We may use these pictures/videos in our school for teaching, arts & crafts, albums, labels and/or advertising.

\_\_\_\_\_ I give permission to                      \_\_\_\_\_ I do NOT give permission to

Acreage Montessori Academy to take **photographs** of my child for the purposes stated above.

\_\_\_\_\_ I give permission to                      \_\_\_\_\_ I do NOT give permission to

Acreage Montessori Academy to take **videos** or have videos taken of my child for the purposes stated above.

I understand that these photos and/or videos **WILL NOT** be sold or distributed to any other individual or business.

\_\_\_\_\_

Parent/Guardian Name (Please print)

\_\_\_\_\_

Parent/Guardian Signature



## Tricycle/Helmet Permission Form

For the protection of your child, we ask that you sign and return this form allowing your child to ride the tricycles on our playground.

Please chose one:

I give permission

I DO NOT give permission

For my child \_\_\_\_\_ to ride a tricycle at Acreage Montessori Academy. Please check one:

I give permission for my child to use one of the school helmets.

I will send my child's helmet to school, clearly labeled.

Parent's Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_





## Permission for Food-related Activities & Special Occasion Food Consumption

Pursuant to 65C-22.005(1)(c)2., F.A.C., licensed childcare facilities must obtain written permission from parents/guardians regarding a child's participation in food related activities. These activities include such things as: classroom cooking projects, gardening, school wide celebrations, and birthdays.

I \_\_\_\_\_ (parent or guardian) give/decline (circle one) permission for my child \_\_\_\_\_ (child's name) to participate in food related activities and special occasions where food is consumed, subject to the conditions indicated below.

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**Permission Options:** (Select and initial one of the options below):

- My child DOES NOT HAVE a food allergy or dietary restriction. He or she **may participate** in activities.
- My child DOES NOT HAVE a food allergy or dietary restriction. He or she **may not participate** in activities.
- My child HAS a food allergy or dietary restrictions. He or she **may not participate** in activities.
- My child HAS a food allergy or dietary restriction. He or she **may participate** in activities, but **must not eat or handle** the following items (please list below):

\_\_\_\_\_

\_\_\_\_\_

**Type of Permission:** (Select one):

- Specific Permission Only for: \_\_\_\_\_ (food activity or Event) \_\_\_\_\_ (date)
- General Permission

I understand that it is my responsibility to update this form in the event that my decision for permission changes. I agree that this form will remain in effect during the term of my child's enrollment.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date