WHITE ROCK MONTESSORI
2026/2027

Full Day (8:55 am - 3:15 pm)
$427.00 (5 days a week)

Half Day (8:55am -1:00pm)
$365.00 (5 days a week

TO HOLD YOUR PLACE, WE REQUIRE THE FOLLOWING:

1) **REGISTRATION FEE:** $150.00 non refundable registration fee.
2) **LAST MONTHS FEES:** One month tuition fees applied to your June I payment.
3) **E-TRANSFER:** E-Transfer your monthly fees on the first of each month to: cobblehillmontessori@gmail.com (September I to May 1)

***DAYS YOUR CHILD WILL ATTEND: _____**

Iunderstand the payment policies and due dates on this fee form. I also understand the policies outlined in the Parent Handbook.

PRINTED: _____
Parent/Guardian Name

SIGNED: _____ DATE: _____

- In case of withdrawal from school, parents are required to give I full calendar month written notice of the withdrawal from the program.
- Please note absence due to illness or holidays are not exempt from payment.
- White Rock Montessori conforms to the public school holidays.
- These fees are discounted as all families are eligible for Ministry Funded Child Care Fee Reduction Initiative Discount.

WHITE ROCK MONTESSORI

14560 North Bluff Rd
White Rock, BC. V4B OBJ
Tel: 604-355-4654
Email: cobblehillmontessori@gmail.com

Name of Child: _____

Birthdate: _____Gender: _____

Starting Date & Days/ week: _____

Mother's Name: _____

Cell: _____Work Ph: _____

Email: _____

Father's Name:
_____

Cell: _____Work Ph: _____

Email:_____

Complete Address: _____
Name and ages of brothers and sisters: _____

Has your child had previous group experiences?

_____

_____

Does your child have any special problems such as medical, allergies, or behavioural issues, which we should know about?

_____

_____

Do we have your permission to use your child's photos on our website, Facebook or other marketing materials? Yes, I give my permission _____No, I am not comfortable allowing this _____

SCHOOL REGISTRATION FORM IMMUNIZATION RECORD

Attach a photocopy of immunization record, or indicate dates that immunizations were received.

Diphtheria, Tetanus and Pertussis (DPT): _____
Polio:_____

Meningitis (Hob D): _____

Measles, Mumps and Rubella (MMR):_____

Emergency Consent Form - White Rock Montessori

Child's name:_____

Birthdate:_____

Address:_____

Child lives with:_____

Mother's name: _____Phone #:_____

Father's name:_____Phone #:_____

Emergency Contact:_____Phone #:_____

Child's Doctor:_____Phone #:_____

1. ALLERGIES:_____
2. Care Card #:_____Date Effective:_____

EMERGENCY HEALTH INFORMATION

Doctor's Name: _____ Phone: _____ _

Address: Care Card Number: _____ _

Special Diet (If any): _____

CONSENT FOR EMERGENCY CARE I authorize the staff at White Rock Montessori to call a medical practitioner or ambulance in the case of accident or illness of my child(ren), if the parent can not immediately be reached.

Print Name:

_____

Signed:_____ Date:_____

(Parent or legal guardian)

FIELD TRIP CONSENT I hereby give White Rock Montessori permission to take my child for walks away from the building that in its discretion are appropriate or necessary. I hereby give Mann Park Montessori permission to take my child on field trips that in its discretion are deemed appropriate or necessary.

Signed: _____ Date: _____ _

ALTERNATIVE PERSON TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ _

Phone: _____

ALTERNATIVE PERSON(S) AUTHORIZED TO PICK UP CHILD

Name: _____ Relationship: _____ _

Ph: _____

Name: _____ Relationship: _____ _

Ph: _____

PERSON NOT PERMITTED TO PICK UP CHILD

Name: _____ Relationship: _____ _

Ph: _____

PARENT OR GUARDIAN PROVIDING INFORMATION

Print Name:

Signed: _____ (Parent or legal guardian) Date: _____

CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency or medical centre when I cannot be contacted.

2. I give consent for my child to receive medical treatment.

Signature of Parent/Guardian Date

PICTURE OF CHILD HERE