

# Creative Montessori

*School*



## CHILD

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Birthdate \_\_\_\_\_

## FAMILY

Parent 1 Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Parent 2 Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Others, besides parents, authorized to pick up your child from school:

Name	Home Phone	Work Phone	Cell
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Note:** Written notification by parents or guardian must be given in case someone other than persons listed here will be picking up child.

## EMERGENCY/MEDICAL

In case of Emergency, if we cannot reach you, whom should we call?

Name	Address
_____	_____
_____	_____

Home Phone	Work Phone	Cell Phone
_____	_____	_____

I hereby grant permission to Creative Montessori School and Daycare to administer First Aid/CPR and to seek medical attention including transportation to \_\_\_\_\_ Hospital for my child \_\_\_\_\_ in the event such treatment is deemed necessary, and I am unable to be contacted. I further consent to medical or surgical treatment by any licensed physician and/or hospital and further consent to administration of necessary anesthetics, medical treatments, tests, transfusions, injections, or drugs and the performing of whatever operations may be deemed necessary or advisable during his or her stay in the hospital.

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

## APPLICATION FOR ENROLLMENT

Date \_\_\_\_\_ Name of Pupil \_\_\_\_\_ Nickname \_\_\_\_\_

Starting Date \_\_\_\_\_ Termination Date (For School use only) \_\_\_\_\_

The class list is made up in the order in which registration fees are received. Your child's name will be placed on a waiting list if the desired class is filled. School opens the day after Labor Day in September and approximately follows the public school schedule for holidays and vacations.

Please indicate the session you prefer for your child.	MORNING	9:00 am - 11:30 am	<input type="checkbox"/>	M	T	W	Th	F
	AFTERNOON	12:30 pm - 3:00 pm	<input type="checkbox"/>	M	T	W	Th	F
	ALL DAY	9:00 am - 3:00 pm	<input type="checkbox"/>	M	T	W	Th	F
	FULL CARE	7:00 am - 5:00 pm	<input type="checkbox"/>	M	T	W	Th	F

## HEALTH HISTORY

Child's Physician/Clinic	Address	Phone
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Child's Dentist	Address	Phone
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Date of last physical exam or visit to health care provider \_\_\_\_\_

Allergies: Yes \_\_\_\_\_ No \_\_\_\_\_ *If yes, please complete an Allergy form.*

Life threatening medical conditions: Yes \_\_\_\_\_ No \_\_\_\_\_ *If yes, please complete an Individual Health Care Plan*

List current medications \_\_\_\_\_

## OTHER INFORMATION

In case of disaster, name and phone number of an out of state person who can be reached:

We publish a class roster every year of children and parents' names, addresses, phone numbers and birthdays. If you do NOT want yours included, please check the box. ☐

## PARENT'S AUTHORIZATION

I authorize the Creative Montessori School and Daycare to provide care for my child. I certify that the information provided in this application is correct to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Return to:

Creative Montessori School  
14944 Juanita Dr NE  
Kenmore WA 98028  
(425) 488-8844

Please include the registration fee.  
Make check payable to CMS.

