Mona Montessori Greentree

4440 Sigma Road Farmers Branch TX 75244 – Phone:972-488-1277

Application for Admission

Child's Last name:	**First Name:**	
Date of Birth:	Place of Birth (City & State):	
Parent's or Guardian Names:		
Home Address:	City:	Zip:
Home Phone:		
Mother's Work Phone:	Father's Work Phone:	
Mobile Phone:	E-Mail:	
With Whom Does the Child Live: Both Parents: ☐ Mother: ☐ Father: ☐ Guardian: ☐		
Phone Numbers where Parents/Guardian can be reached while child is in care and in case of emergency:		
Name:	*Phone:*	
Address:		
Guarantor: (Person Responsible for Registration and Fees):		
Mother's Employer:	Father's Employer:	
List who else is authorized to pick your child from The Academy – (will have to show their picture ID, so please provide their Driver License number). Include spouse if authorized to pick when the child does not live with both parents.		
Name Phone No. & relationship:		
Name Phone No. & relationship:		
Name Phone No. & relationship:		

EMERGENCY MEDICAL CARE: In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to: The physician (Name): ___________________Phone: ___________
Name of Emergency Care Facility: ________________________ Address_________________ Phone:_____________
I give consent for the center to secure any and all necessary emergency medical care for my child.
Signature Parent or Legal Guardian: ________________________________

PLEASE PROVIDE IMMUNIZATION RECORDS. IF THE CHILD IS 4 YEARS OR OLDER, WE ALSO REQUIRE HEARING AND VISION TEST RESULT REPORTS (SEE HEALTH REQUIREMENTS FORM).

Transportation: I hereby give ☐ do not give ☐ consent for my child to be transported by facility's staff
on field trips ☐ to and from school ☐ For Emergency Care ☐

Water Activities: I hereby give ☐ do not give ☐ my consent for my child to participate in water sports provided by the facility: splashing or wading pools ☐ swimming pools ☐ Water activities (Table/sprinkler) play ☐

School Age Children: My child attends the following school and his/her immunization records are on file at that school and immunizations and TB test are current.

Please consider my child for admission. I understand there is an annual registration fee. Please read the Fee Schedule, Terms, and Conditions.

I have read and agree to the Fee Schedule & T/C's

***Parent (Guardian): Signature* ____________________ *Date:* __________*Driver License No.* ____________**

For office use only: Class: ____________________Start Date: ____________ Drop Date: ____________
Fees ($): __________ ___Weekly _____ Monthly
Days in Care: M T W TH F OR (M –F) Hours in Care: Circle one (7 to 6) (7 to 4) (9-4) (9-6)
Comments: ____

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Emergency Authorization

Child's Last Name: First Name:

Parents' Names:

Address:

Guardians Name (If Different From Parents):

Home Phone Number:

Mother's Work Number: Mobile Phone:

Father's Work Number: Mobile Phone:

If a parent (guardian) cannot be reached in case of emergency, the Center has permission to contact the following persons in the order listed:

Name: Phone:

Address

Name: Phone:

Address

Emergency contacts must be reliable persons, who could make themselves available immediately and who have transportation during your child's attendance hours. They must be people whom your child knows well, and who can and are ready to pick your child from school and provide care.

In case the services of a physician are required before either a parent (guardian) or one of the emergency contacts can be reached, the following doctor may give my child any treatment necessary. I (the parent or guardian) assume responsibility for payment of such professional service.

Doctor: Phone:

Address:

Emergency Care Facility Name & Address:

Is Your Child Allergic To Any Medication: Pls. Specify:

Is Your Child Allergic To Any Other Substance:

In case of an emergency, when a parent, guardian, emergency contact, or the above physician cannot be reached, the Center has my permission to take my child by car, van or ambulance to a hospital. The hospital personnel have my permission to treat the child.

Signature of Parent or Guardian Date

Form: MMA/103-1

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HEALTH REQUIREMENTS

CHILD'S NAME: Chils's Date of Birth:

IMMUNIZATIONS	2 months	4 months	6 months	12 months	15 m	18 months	19-23 m	2-3 yrs	4-6 yrs	
Hepatitis B										
Rotavirus										
DTP										
Haemophilus Inf Type B										
Pneumococcal										
Inactivated Poliovirus										
Influenza										
Measles, Mumps,Rubella										
Varicella										
Hepatitis A										

TB TEST ☐ Positive ☐ Negative Signature:________________________ Date: ______________

Varicella (chikenpox) vaccine is not required if your child has had chickenpox disease. If you child has had chickenpox, please complete the statement:

My child had varicella disease (chickenpox) on or about (date)___________ and does not need varicella Vaccine.

Parent Signature: ____ Date: ___________________

REQUIREMENTS FOR EXCLUSION:

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reasonof conscience, including religious belief, on the fom described by Section 161.0041 Health and safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision and hearing screening conflicts with the tenets or practice of a church or regious denomination that I am an adherent or member of.

ADMISSION REQUIREMENTS: ONE OF THE FOLLOWING MUST BE PRESENTED WHEN YOUR CHILD (UNDER THE AGE OF 5) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

O - HEALTH-CARE Professional's statement: I have examined the above named child within past year and find that he/she is physically able to take part in the day care program.

Physician's Signature: ____ Date: _______________________

O - A signed and dated copy of of a health care professional's statement is attached.

O - Medical diagnosis and treatment conflict with the tenets and practices of recognizedreligious organization, which I adhere to or a member of. I have attached a signed and dated affidavit stating this.

O - My child has been examined within the past year by a health care professional and is able to participate and in the day care program. Within 12 months of admission, I will obtain a health care profesional's signed statement and submit it to the child care operation.

VISION: R 20/___ L 20/_______ O PASS O FAIL Signature ______ Date _____

HEARING: 1000HZ: R____ L_____ 2000HZ: R____ L: ____ 4000HZ: R: ______ L: ________

R: O PASS O FAIL L: O PASS O FAIL Signature ___________ Date _____

NAME AND ADDRESS OF HEALTH CARE PROFESSIONAL

____

Health Care Professional Signature:: ____ Date: ___________

ADDITIONA INFORMATION

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immunize/public.shth

GANG FREE ZONE: Under the Texas penal code, any area within 1000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalities.

PRIVACY STATEMENT: DFPS values your privacy, for more information, read privacy and security Policy at http://www.dfps.state.tx.us/policies/privacy.asp

Child's Parent or Legal Guardian: ________________________________ Date: ___________ Center Designee: _____________________ Date : ________