# The Montessori School of Camden
# Enrollment Record

## Child Information

Full name _____ Nickname _____ Generation (Jr, II, III, etc.) _____

Date of Birth *(mm/dd/yy)* ___/___/___ Gender ❑ F ❑ M Race/Ethnicity (check all appropriate):

❑Asian ❑ Black/African-American ❑ Native American ❑ Native Alaskan ❑ Native Hawaiian ❑ White ❑Hispanic/Latino ❑ Other

Child lives with ❑ both parents ❑ mother ❑ father ❑ grandparent ❑ other *(specify)* _____

Address _____ Phone _____
City State Zip

Mailing address (if different from home) _____
City State Zip

**PERSONAL RECORD**

| **FATHER/Guardian ❑ may pick up** | | **MOTHER / Guardian ❑ may pick up** | |
|---|---|---|---|
| Name: | | Name: | |
| Address: | | Address: | |
| City, State, Zip: | | City, State, Zip: | |
| Place of Employment: | | Place of Employment: | |
| Occupation: | | Occupation: | |
| Home phone: | | Home Phone: | |
| Cell phone: | Carrier: | Cell Phone: | Carrier: |
| Work phone: | | Work Phone: | |
| Email address: | | Email address: | |

## Emergency Contact Information

No child will be allowed to leave the school with anyone except parents without written permission from parent. Please allow 48 hours notice for changes to authorized pick-up list.

**Names of persons authorized to pick up child or to be contacted in an emergency if parents cannot be reached:**
(Please attach a photocopy of a driver's license for all persons on the pick-up list)

Name_____ Name_____
Phone_____ Phone_____
Address _____ Address_____
Relationship _____ Relationship_____

Name_____ Name _____
Phone_____ Phone_____
Address _____ Address_____
Relationship _____ Relationship_____

Name_____ Name _____
Phone_____ Phone_____
Address _____ Address_____
Relationship _____ Relationship_____

Name_____ Name _____
Phone_____ Phone_____
Address _____ Address_____
Relationship _____ Relationship_____

Name_____ Name _____
Phone_____ Phone_____
Address _____ Address_____
Relationship _____ Relationship_____

**Information for Office Use Only**

**Health Information**

Health Insurance Co._____ Policy Holder's Name_____ Policy #_____

My child receives regular medical care from ❑ Health Clinic ❑ Emergency Room ❑ Family Doctor ❑ Other

Physician's Name _____ Physician's #_____
Please list health Information including limitations, allergies, asthma, diabetes, epilepsy and regular medication: _____

_____
Did your child weigh less than 5.5 pounds at birth? ❑ Yes ❑ No

I certify that to the best of my knowledge _____ is in good mental and physical health and able to participate in The Montessori School of Camden programs. Certificate of Immunization or waiver must be on file.

**Best Emergency Contact Number**_____

Signature of parent or guardian _____ date _____

**Child's Prior Care / Education Provider Infant, Toddler, and Primary Only)**

❑ Head Start ❑ Public PreK ❑ Unknown

My child attended (check one only) ❑ full day ❑ partial day Name of Provider: _____

My child's care last year was in a home by an informal care provider (check one): ❑ Parent or relative ❑ Non-relative

**Family Income Range**
❑$0 - $10,000 ❑ $10,001 - $20,000 ❑ $20,001 - $30,000 ❑ $30,001 - $40,000 ❑ $40,001 - $50,000
❑ $50,001 - $60,000 ❑ $60,001 and above

**Family Literacy Services**
Who in your family has participated in a school district Family Literacy Program such as adult literacy, adult education (GED, High School Diploma, ESL), parent education, child development, or parent and adult/child interactive literacy?

❑ Both Parents ❑ Mother ❑ Father ❑ Guardian/Grandparent ❑ No one

Did your child ever participate in school district Family Literacy Services? ❑ Yes ❑ No
If "Yes," please check how long: ❑ 1 Year ❑ 2 Years ❑ 3 Years ❑ 4 or more Years