



# CMS

## Central Montessori School

### APPLICATION FOR ADMISSIONS:

Starting Date: m/\_\_\_\_\_ d/\_\_\_\_\_ y/\_\_\_\_\_

**Toddler Program**

(18 months to 3 yrs.)

2 Full Days  3 Full Days  4 Full Days  5 Full Days   
2 Half Days  3 Half Days  4 Half Days  5 Half Days

**Casa Program:**

(3 years to 5 yrs.)

2 Full Days  3 Full Days  4 Full Days  5 Full Days   
2 Half Days  3 Half Days  4 Half Days  5 Half Days

Extended Hours: (7:00 – 8:30 a.m.) Yes  No.

Extended Hours: (3:00 – 5:00 p.m.) Yes  No.

Approximate Drop-Off Time \_\_\_\_\_ Pick-Up Time \_\_\_\_\_

### CHILD'S INFORMATION

Child's Last Name			
Child's Given Names (Underline name used)			
Date of Birth	Month	Day	Year
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>		
Home Address			
	City		Postal Code
Home Telephone Number			
Name of Last School Attended			
Languages Spoken at Home			

## FAMILY INFORMATION

	<b>Mother/Guardian</b>	<b>Father/Guardian</b>
Title (Circle one)	Mrs. Ms. Dr. Other:	Mr. Dr. Other:
Last Name		
First Name		
Address (if different from child)		
Employer Name and Address		
Work Telephone Number		
Home Telephone Number		
Cell Telephone Number		
Email Address ( <b>Please Print</b> )		
Marital Status	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/>	
Applicant lives with	Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
Correspondence to be sent to	Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Other _____	
Siblings Name(s)	Age(s)	Gender
1.		
2.		

**MEDICAL INFORMATION**

Name of Child's Physician	
Physician's Telephone Number	
Physician's Address	
Immunization is Attached	Yes <input type="checkbox"/> No <input type="checkbox"/> Reasons, if No _____
List Child's Allergies	
Does your child have any special dietary requirements?	
Does your child have any special physical, cognitive/ social or emotional needs?	
History of Communicable Diseases	

**EMERGENCY AND CHILD PICK-UP INFORMATION**

Name of contact person in the event of an <b>emergency</b> :		
Name	Telephone & Address	Relationship
Other people allowed to <b>pick-up child</b> from the school:		
Name	Telephone	Relationship

In order for your child's application to be processed it is necessary to include the following items:

1. A copy of your child's latest report and any other educational assessment reports.
2. A non-refundable deposit equivalent to your monthly tuition. (This will pay the June 2024 tuition ONLY).

3. A non-refundable registration fee of \$300.00 payable to Central Montessori Schools.
4. A copy of your child's Yellow California Immunization record.

Note: Thirty days written notice is required in the event of an early withdrawal from the School and at this time, the school will return any post-dated checks on file.

Please complete this application form and mail or drop it off at the school with all necessary items in the enclosed envelope to:

**Central Montessori School  
286 North El Camino Real,  
Encinitas - CA. 92024 – 2864**

- I / We have read the Policies & Guidelines set out by the school and understand all the information given. Yes [  ] No [  ]
- I / We have read and understand the fee information set out on the fee schedule. Yes [  ] No [  ]
- I/ We agree to have photos of, and/or creative material produced by my child to be used by the school as promotional material. Yes [  ] No [  ]
- I/We give Central Montessori School permission to give our email to other parents attending the school. Yes [  ] No [  ]

**Name of Parent or Guardian:** \_\_\_\_\_  
(Please print)

\_\_\_\_\_  
**Date (month/day/year)**

\_\_\_\_\_  
**Parent or Guardian Signature**

**THANK YOU FOR SELECTING CENTRAL MONTESSORI SCHOOL.**

<b><u>Office use only:</u></b>			
Application fee received:	Yes [ <input type="checkbox"/> ]	No [ <input type="checkbox"/> ]	Date: _____
Deposit received:	Yes [ <input type="checkbox"/> ]	No [ <input type="checkbox"/> ]	Date: _____
Post-Dated Checks or Direct Debit received:	Yes [ <input type="checkbox"/> ]	No [ <input type="checkbox"/> ]	Date: _____
_____	<b>Date of Withdrawal</b> m/____ d/____ y/____		
<b>Signature of Administrator</b>			