Central Kitsap Montessori
(360) 698-7620
www.CKMontessori.com

Application for Enrollment

Official Use Only

Date Received: _____
Deposit Paid: _____
Start Date: _____

CLASS PREFERRED: (Please mark the classes in order preferred, **1** being your first choice through **4** as your last choice.)

Blue (M-Th, AM) _____ Yellow (M-Th, PM) _____ Red (T-F, AM) _____ Green (T-F, PM) _____

STUDENT'S FULL NAME:_____SEX:_____

NAME COMMONLY USED:_____BIRTHDATE:_____

ADDRESS:_____CITY:_____

ZIP:_____HOME TELEPHONE:_____

[ ] Check here if parents do not live together. Please provide additional address and home phone on back.

MOTHER'S NAME:_____ WORK PHONE:_____

CELL PHONE:_____ TEXT? _YES / NO_ OK TO SEND PHOTOS? _YES / NO_

FATHER'S NAME:_____ WORK PHONE:_____

CELL PHONE:_____ TEXT? _YES / NO_ OK TO SEND PHOTOS? _YES / NO_

EMAIL ADDRESS (Will only be used for newsletters and other communications from CK Montessori.):

_____

GENERAL HEALTH STATUS OF STUDENT (Describe any handicaps/allergies/special problems):

_____

_____

DO WE HAVE PERMISSION TO USE PHOTOS OF YOUR CHILD ON OUR WEBSITE, AND/OR

NEWSLETTER? _YES / NO_ If yes, please initial here: _____

DO WE HAVE PERMISSION TO POST PHOTOS OF YOUR CHILD ON OUR FACEBOOK PAGE?

YES / NO If yes, please initial here: _____

WOULD YOU LIKE US TO "TAG" YOU IF WE POST A PHOTO OF YOUR CHILD ON FACEBOOK?

YES / NO / NOT APPLICABLE

Please remit this form with a non refundable deposit of $100.00.
(Deposit will be deducted from June's tuition.)
Thank you for your interest in our school!

Central Kitsap Montessori * 10323 Central Valley Rd NE * Poulsbo, WA 98370 * (360) 698-7620

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Emergency Information and Release Form

CHILD'S NAME_____ TELEPHONE_____

ADDRESS_____ BIRTH DATE_____

_____

FATHER'S NAME_____ CELL PHONE_____

MOTHER'S NAME_____ CELL PHONE_____

Additional persons who may be called in an emergency:

NAME_____TELEPHONE_____

NAME_____TELEPHONE_____

Physician to be called in an emergency:

NAME_____TELEPHONE_____

Unless otherwise requested, the school's first action in an emergency will be to call the paramedics to administer emergency first aid. If the paramedics judge that hospitalization is necessary, they will transport the child to the nearest available emergency room. Parents must be present, or have this consent form on file before treatment may be given.

IS THIS PROCEDURE ACCEPTABLE TO YOU? YES_____ NO_____

IF NOT, WHAT ACTION SHOULD BE TAKEN? _____

_____

PLEASE LIST ALLERGIES, INCLUDING DRUG REACTIONS:_____

CHRONIC ILLNESSES:_____

REGULAR MEDICATIONS:_____

ARE IMUNIZATIONS UP TO DATE? :_____

I, _____, the natural parent/legal guardian of _____ authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health when I cannot be contacted. I waive my right of informed consent of such treatment.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

Authorization Form

for Automatic Withdrawal

Name (Please Print) _____ Telephone _____

Financial Institution Name _____ Type (i.e. Chk/Sav) _____ Child's name _____

Email address for bank use _____

[ ] **New Authorization -** I authorize and request Central Kitsap Montessori, Inc. to withdraw the monthly tuition amount automatically, on the first banking day of every month during the school year. I may terminate this agreement at any time by completing the cancellation portion of this form.

[ ] **Change Authorization –** I authorize and request Central Kitsap Montessori, Inc. to make the automatic payment changes indicated above.

[ ] **Cancellation Statement -** I authorize and request Central Kitsap Montessori, Inc. to terminate my authorized withdrawal.

Signature _____ Date Signed _____

[ ]

ATTACH VOIDED CHECK HERE

[ ]