



46 GREY STREET  
EAST AURORA, NY 14052  
716.652.5092

Date of Application: \_\_\_\_\_

**Program Enrollment**

- Toddler  Mon. Wed. Fri. 9:00-11
- Preschool  Mon. - Fri. 9:00 - 11:30
- Kindergarten/K+  Half Day  Full Day

**EAST AURORA MONTESSORI APPLICATION**

Child's Name: \_\_\_\_\_ Gender: (M) (F)

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birthday: \_\_\_\_\_

Email: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address  
(if different from above): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**PERSONS AUTHORIZED TO PICK UP CHILD**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**FOOD ALLERGIES AND MEDICAL CONDITIONS**

**CHILD'S SIBLINGS & BIRTHDATES**

The signature below indicates that the handbook has been read and that non-compliance to school policy will terminate enrollment in East Aurora Montessori School.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This Application must be accompanied by a \$100.00 Non-Refundable Fee.  
(Please fill out Enrollment Contract on reverse side)

# ENROLLMENT CONTRACT

The following contractual agreement is entered into by and between East Aurora Montessori School (herein referred to as "school") and the parents or legal guardians (herein referred to as "parents" of :

\_\_\_\_\_ (Child)

## FOR MUTUAL CONSIDERATION IT IS AGREED

- \* The school accepts the child as a student for the school year commencing on \_\_\_\_\_ (date), and ending on \_\_\_\_\_ (date).
- \* Parents agree to pay to the school tuition of \_\_\_\_\_ per year.
- \* The registration fee of \_\_\_\_\_ is due with the application and is non-refundable.
- \* Parents agree to pay tuition: (Check one)
  - By the year, due August 1st, in the amount of \_\_\_\_\_ .
  - By the semester, due Aug./ Jan., in the amount of \_\_\_\_\_ .
  - By the month, beginning August 1st, due the first day of each month, in the amount of \_\_\_\_\_ .
- \* The school reserves the right to terminate the child's participation in the school at any time upon notification of parents and refund of a pro-rata share of tuition.
- \* Should any payment be delinquent for a period of 15 days, a late fee of 10% of the amount due will be assessed. If payment is not received within 15 days after notification of delinquency, the school may terminate the child's enrollment. A charge of \$20.00 will be levied for any check returned for insufficient funds.
- \* Parents acknowledge that the school assumes no responsibility for the transportation of the child to and from school.
- \* Your signature below indicates that you agree to release East Aurora Montessori Inc., and the owners, directors, teachers and staff from any liability for injuries or illnesses resulting from conditions or circumstances beyond their control.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- \* I hereby authorize hospitalization and emergency medical treatment of my child in the event neither I nor the emergency contact person can be reached in a reasonable period of time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EAST AURORA MONTESSORI INC.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**EAST AURORA MONTESSORI MEDICAL REPORT**

CHILD'S NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_

**IMMUNIZATIONS (PLEASE GIVE DATE(S)):**

DPT \_\_\_\_\_

HEPATITIS B (3 DOSES) \_\_\_\_\_

HIB VACCINE \_\_\_\_\_

VARICELLA \_\_\_\_\_

POLIO \_\_\_\_\_

MMR \_\_\_\_\_

TUBERCULIN TEST (TYPE AND RESULTS) \_\_\_\_\_

1. ARE THERE ALLERGIC PROBLEMS? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, SPECIFY: \_\_\_\_\_

2. IS A SPECIAL DIET REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, SPECIFY: \_\_\_\_\_

3. IS MEDICATION REGULARLY TAKEN? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, SPECIFY: \_\_\_\_\_

4. ARE THERE ANY CONDITIONS REQUIRING SPECIAL ATTENTION BY THE SCHOOL? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, SPECIFY: \_\_\_\_\_

LIST ANY SPECIAL RECOMMENDATIONS ABOUT CHILD'S HEALTH (USE REVERSE IF NEEDED): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ PHYSICIAN SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL NAME AND #: \_\_\_\_\_

MAY EMERGENCY MEDICAL ATTENTION BE ADMINISTERED BEFORE PARENT ARRIVES? \_\_\_\_\_ YES \_\_\_\_\_ NO

PARENT SIGNATURE: \_\_\_\_\_