MONTESSORI SCHOOL OF DOUGLAS COUNTY, INC.

P.O. BOX 272
Douglasville, Georgia 30134
770-949-3115

APPLICATION FOR ADMISSION

Date: _____

Application is hereby made for admission of: _____,
as a student in the Montessori School of Douglas County beginning on _____, 20____.

The following information is submitted as part of this application:

Date of Birth: _____Sex: _____
Month Day Year

Home Address: _____

_____
City State Zip Code Home Phone Number

Father's Cell Phone #:_____Mother's Cell Phone #:_____

Father's Name:_____Occupation:_____
Father's email address:_____

Business Address:_____Bus.Phone:_____

Father's Educational Background: High School:_____ College:_____

Mother's Name:_____Occupation:_____
Mother's email address:_____

Business Address:_____Bus.Phone:_____

Status of Parents: Married: _____Divorced: _____Separated: _____Widow/Widower: _____

Siblings Name: _____Birthday: _____

_____Birthday: _____

Previous Preschool or Montessori Experience?: _____How long: _____

Any Language other than English spoken at home? _____

Other Adults in the home?_____ Relationship:_____

Does your child have any unusual fears? _____

Why have you chosen Montessori Education for your child? _____

Email ________________________________

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Check schedule you interested in:

__Morning Program 9:00 a.m. – 12:00 p.m.

__Afternoon Program 9:00 a.m. – 3:00 p.m.

__Extended Day Program 7:00 a.m. – 6:00 p.m.

Emergency Contact Other than Parent or Guardian:

1. Name: ____Cell Phone:_________________

2. Name: ____Cell Phone: ________________

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Medical Release Form:
In case of an emergency, I understand every effort will be made to contact me. In the event I that the parent or guardian cannot be reached, the school will be authorized to secure medical attention as may be necessary; meaning to the nearest doctor or hospital. The parents are responsible for payment of expenses incurred.

Is your child allergic to any medication or is there any other medical information the doctor might need to know prior to treating your child? If so, please give all details:

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____________________________________ ____
Child's Name Name of Pediatrician

____________________________________ ____
Parent's Signature Pediatrician's Phone Number

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Certificate of Immunization:
By law we are required to have a health form on file for each child. The above form should be returned to us within one week of enrollment.