Parent Checklist ~ Enrollment Forms:

Please print, review and fill out the following forms, and return no later than your child's **first day.**

- ❑ Enrollment Application - fill out if you have not previously submitted
- ❑ Consent Forms
- ❑ Birthday Story - to be completed by your child's birthday
- ❑ Physical - to be completed by your child's physician
- ❑ DCFS Licensing Standards - A separate link is provided for the DCFS Licensing Standards. Please read and keep for your records and then sign the form at the end of this document.
- ❑ Copy of child's Birth Certificate - bring this in for your child's file

- ❑ Parent Packet- A separate link is provided for the Parent Packet. Please review and keep for your records as it contains general information and policies about the Montessori Children's Centre.

Montessori Children's Centre Enrollment Application

3 Yount Drive Bloomington, IL 61704 (309) 663-8736
mccmontessori@gmail.com
www.montessorichildren.net

CHILD:

Full Name (First, Middle, Last) Preferred Name

Male_____ Female_____
Birth date

Home Address

City State Zip Home Phone

PARENT/GUARDIAN:

Marital Status_____
Name

Home Address

City State Zip Home Phone

Place of Employment Occupation

Employment Address Work Phone

Cellular Phone E-mail Address

PARENT/GUARDIAN:

Marital Status_____
Name

Home Address

City State Zip Home Phone

Place of Employment Occupation

Employment Address Work Phone

Cellular Phone E-mail Address

In Case of an Emergency (if parents cannot be contacted)

Emergency Name Home Phone Work Phone

Address City State Zip

Physician Name Phone

Address City State Zip

Our weekly newsletter will be sent to the email addresses listed on the front of the application unless otherwise specified here_____

List names and ages of siblings _____

Please list any allergies (food, medications, insects) or food restrictions (vegetarian, etc.) your child has
_____

Are there any special educational, physical, or emotional needs of your child? _____
_____
_____

_____ Yes, I understand the hours of Montessori Children Centre are from 6:45 a.m. to 5:30 p.m.

Name of program(s) in which your child has been enrolled (currently or previously) _____
_____

Why do you want your child enrolled in Montessori Children's Centre?
_____
_____
_____
_____

Did someone refer you to Montessori? _____ If so, we would like to know the names of those who referred you so we can show our appreciation. _____

Have you heard about Montessori Children's Centre in another way? Check all that apply:
__Facebook/Instagram __website __saw school/sign __Yelp __open house advertisement
__other:_____

What information can you give to help us know your child better? _____
_____
_____
_____

RETURN THIS APPLICATION TO RESERVE A POSITION ON THE WAITING LIST AT THE MONTESSORI CHILDREN'S CENTRE. ADMISSION WILL BE MADE BASED ON THE AVAILABILITY OF SPACE AND DATE OF RECEIPT OF THE APPLICATION FOR ADMISSION. SIGNATURE OF THIS APPLICATION ACKNOWLEDGES RESPONSIBILITY FOR THE PROMPT AND COMPLETE PAYMENT OF TUITION FOR THE APPLICANT.

_____
Parent(s)/Guardian(s) Signature Date

_____
Parent(s)/Guardian(s) Signature Date

Montessori Children's Centre

Consent Form Packet

Student Name:_____ **Start Date:**_____

Montessori Children's Centre strives to provide you and your child the best possible service. To assist in this process, we have compiled this consent form packet. Please print, review and fill out the following forms, and return on or before your child's first day. If you have any questions or concerns regarding any form, please do not hesitate to contact us for additional information.

Emergency Medical Care Instructions

In case of illness or accident, I hereby authorize the Montessori Children's Centre to obtain emergency medical care for _____ (Child's Name).
Preferred Physician _____
Address _____ Phone _____
Preferred Hospital _____
Address _____ Phone _____

Date: _____ Signature: _____

Child Pick-Up Permission

I authorize only the following individuals to pick up my child when I am unavailable. MCC will not release your child to anyone unless they are listed below or we are notified in writing by the parents/guardians. Parents wishing to pick up children must also have their names included on this list.

Name	Address	Telephone

Date: _____ Signature: _____

Directory Information Release

I give permission to have my child's name, parents' names, home address, email and telephone number listed in a directory to be given only to families, upon their request, of the children enrolled in MCC.

Date: _____ Signature: _____

Permission to Administer Prescription or Over-the-Counter Medicine

I authorize the Montessori Children's Centre to administer prescribed or over-the-counter medicine to my child, as per specified written instructions, from the parents/guardians. To least disrupt your child's day, MCC gives medicine after lunch and before siesta begins.

Date: _____ Signature: _____

Release of Information Permission

I authorize the Montessori Children's Centre to release information about my child upon receiving notification regarding such an authorized request (typically from your child's next school).

Date: _____ Signature: _____

Field Trip Permission

MCC may take nature walks and field trips periodically. MCC will provide responsible adult supervision for these excursions. Your signature will give your permission for your child to participate.

Date: _____ Signature: _____

Sunscreen Permission

Your signature will give your permission for teachers to apply sunscreen, as provided by parents/guardians, on your child when appropriate.

Date: _____ Signature: _____

Student Picture Usage Policy

Yes No

❑ ❑ I GIVE MY PERMISSION for MCC to use my child's image or voice in photographs, recordings, or video for internal purposes. MCC may use these for the enhancement or development of their teaching methods. MCC will not use information, such as first or last names, in any presentation. MCC will restrict these pictures for use at Montessori Children's Centre and will **not** be available to others who are not directly affiliated with our school.

Yes No

❑ ❑ I GIVE MY PERMISSION to allow organizations in the media (newspapers, television, radio) when covering stories about Montessori Children's Centre, to take pictures, videos, or recordings of my child without compensation.

Yes No

❑ ❑ I GIVE MY PERMISSION to use **pictures** of my child (no first or last name mentioned) on the MCC Facebook page, MCC website, or MCC publications, without compensation.

Yes No

❑ ❑ I GIVE PERMISSION to use **video clips** of my child (no first or last name mentioned) on the MCC Facebook page, MCC website, or MC publications, without compensation.

Date: _____ Signature: _____

Pick-Up Policy

The hours of operation at Montessori Children's Centre are 6:45 a.m. 5:30 p.m., Monday through Friday.

For any child that is picked up later than 5:30 p.m., there will be a charge of $1 per minute. Two staff members are always present, therefore payment is payable upon arrival to the teachers that stay after 5:30 pm to care for your child.

If a parent or guardian does not pick their child up by 5:30 pm and has not contacted MCC, staff will attempt to contact parents/guardians at all numbers listed on our contacts. If parents cannot be reached after trying those numbers, staff will begin calling emergency contacts.

If, after one hour, we are unable to make contact with parents/guardians or emergency contacts, we will notify the police so they may assist in finding parents or emergency contacts.

It is extremely important that you keep all of your contacts and emergency contacts up-to-date with MCC so that we will be able to contact you or someone else in the event that you can't be reached.

In the event that a parent/guardian is late, we will provide the same level of care for your child and will not make the child feel responsible in any way for the situation. Discussion of this situation will only be with the parent/guardian and never with your child.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

Family Vacations/Days Missed Tuition Payment Policy

When you accept a position at the Montessori Children's Centre, a Parent Information Packet is given to your family. This packet of information outlines and explains our policies and procedures. Signature of this form acknowledges that you have read and understood the information within the Montessori Children's Centre Parent Information Packet. The following sentences are from the Parent Information Packet:

"Annual tuition may be paid weekly, bi-weekly, monthly, or by the semester…Because the programs at the Montessori Children's Centre are year-round, tuition is not credited for days missed by your child".

With this policy stated, if you choose to take a vacation, it is your responsibility to continue full tuition payments to Montessori. Whether the vacation is a few days or a few weeks, our policy remains. If an extended vacation is to be taken, resulting in 4 weeks or more of absences, we ask that you pay ½ of the tuition (for the missed weeks) prior to leaving. The remaining balance (the second ½) is due upon your return.

We thank you for understanding and complying with our policies and procedures. If you have any questions, please do not hesitate to contact Rachel Broach (309-530-6777), Executive Director or Stacy Hanks, Director.

Signature: _____ Date: _____

Withdrawal Policy

Signature of parties responsible for tuition payments:

_____(Father/guardian)

_____(Mother/guardian)

_____(Other)

Withdrawal Policy

Montessori Children's Centre requires **written notice 4 FULL WEEKS** prior to withdrawal from the program. We always start students at the beginning of the week; therefore, when written notice is given it takes effect starting the following week. *Ex:* If you give written notice on a Monday-Friday, the first of the 4 weeks starts the *following* Monday.

I understand and accept the terms of the Montessori Withdrawal Policy and start date.

_____ _____

Parent Signature Date Director Signature Date

Written Notice of Student Withdrawal

(Please do NOT fill out until time of withdrawal. Refer to Withdrawal Policy Box above.)

Student Name_____

Student Withdrawal Date:_____

_____ _____

Parent Signature Date Director Signature Date

Guidance and Discipline Policy

MCC will administer all discipline in a loving, consistent, fair, and positive manner. Parents will be notified of serious discipline problems immediately. However, even minor problems can be solved through communication and consistency between school and home. This communication serves as a valuable tool to enable both teachers and parents to have similar expectations in the guidance and discipline of their child.

In 2010, the Montessori Children's Centre began implementing a new discipline program called "Conscious Discipline" developed by Dr. Becky Bailey. No use of physical punishment is ever used. This loving discipline compliments our Montessori philosophy by allowing children to acknowledge their emotions by giving them helpful tools to handle their feelings in an appropriate manner. It is a comprehensive social and emotional intelligence classroom management program that empowers both students and teachers. We also give our parents monthly information to allow them to learn the same methods and techniques we use at school. We feel that it is important for both parents and teachers to work together, providing consistency as a team, to help the children. We hope this will be a positive tool to benefit children both at school and at home.

In the case of extreme disciplinary problems, MCC will make every attempt to work together with parents to establish specific ground rules and expectations for the future. However, if these attempts fail to meet the child's individual needs both staff and parents should reevaluate the benefits of the child staying in such a program. Any child whose presence is detrimental to the group as a whole shall be dismissed from the Montessori Children's Centre.

I/We read, understand, and MCC's policy on guidance and discipline:

Parent Signature_____ Date_____

Personalized Birthday Story

On each child's birthday, we have a special ceremony to celebrate his or her life. We place a sun in the center of the red line, and the birthday child holds the earth in his or her hands and walks around the sun as many times as the earth has revolved around the sun in his or her lifetime. For example, if Jon is turning five, he revolves around the sun five times. As the child is walking, the teacher is telling the class about what he or she was doing each year of his life. The children have had lessons on this and know the earth rotates on its axis every day and the earth revolves around the sun one time each year.

We like to have input from the parents on the highlights of your child's life. Some ideas of things to list are: learning to walk, learning to ride a bike, going on a special vacation, starting school at Montessori, and any other special milestones in your child's life. **If bringing a snack to celebrate your child's birthday, please remember our DCFS-mandated policy of no home-baked food and peanut products.** Thank you!

Name_____ Date of Birth_____ Time_____

Weight:_____ Length:_____ First word(s): _____

Birth to 1 year: _____

_____

_____

_____

1 to 2 years old: _____

_____

_____

_____

2 to 3 years old: _____

_____

_____

_____

3 to 4 years old: _____

_____

_____

_____

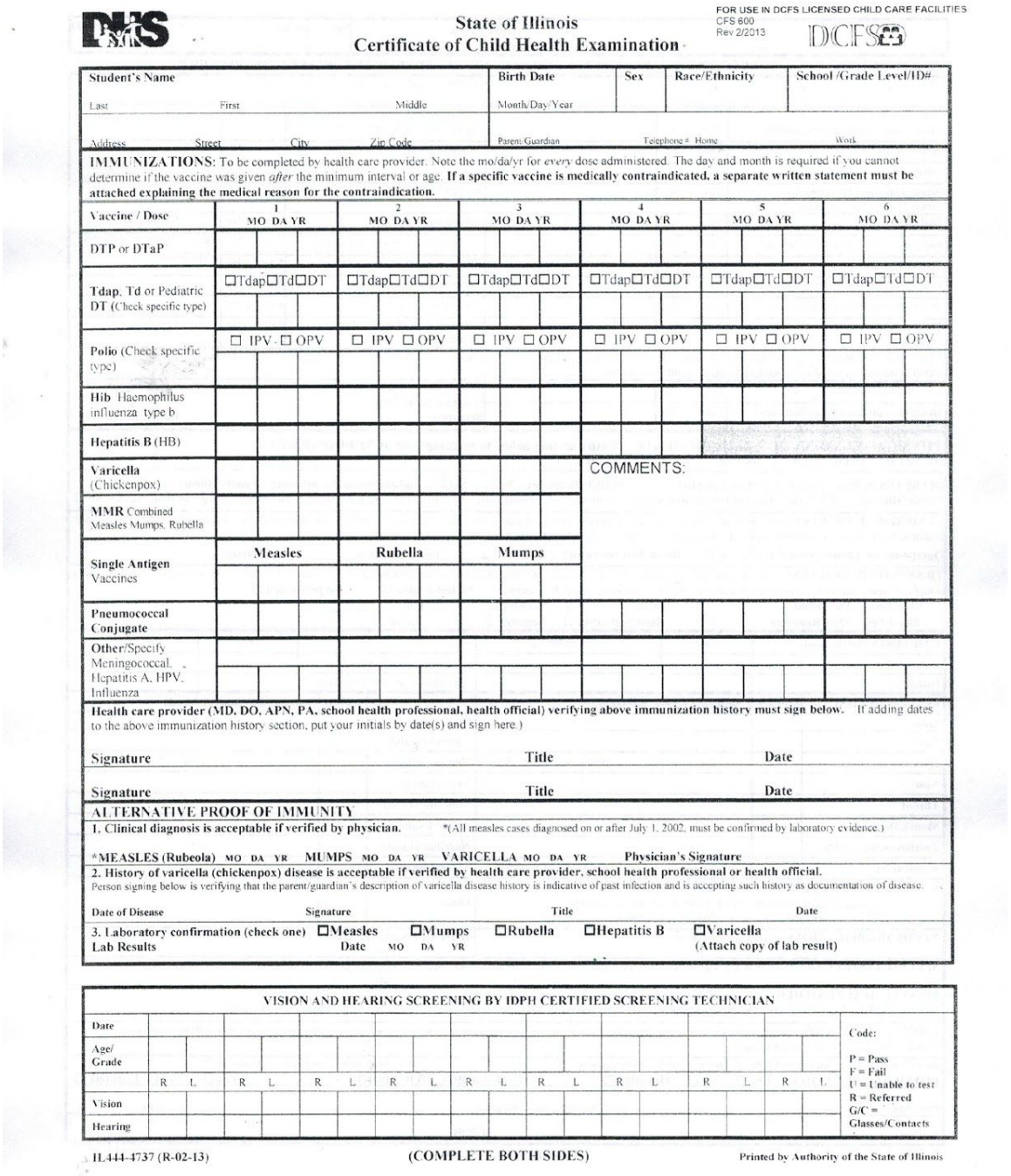
4 to 5 years old: _____

_____

_____

Physical Form

This form is to be filled out by a Physician. You may use the form provided by the Pediatrician's office.



FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

State of Illinois
Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /Grade Level/ID#
Address (Street / City / Zip Code)	Parent/Guardian	Telephone # Home	Work	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap, Td or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps, Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

COMMENTS:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
Age/ Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																				
Hearing																				

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

IL444-4737 (R-02-13) **(COMPLETE BOTH SIDES)** Printed by Authority of the State of Illinois

Last	First	Middle	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)				**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ • Bridge ☐ • Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**
HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _____

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS Yes** ☐ **No** ☐ **Limited** ☐

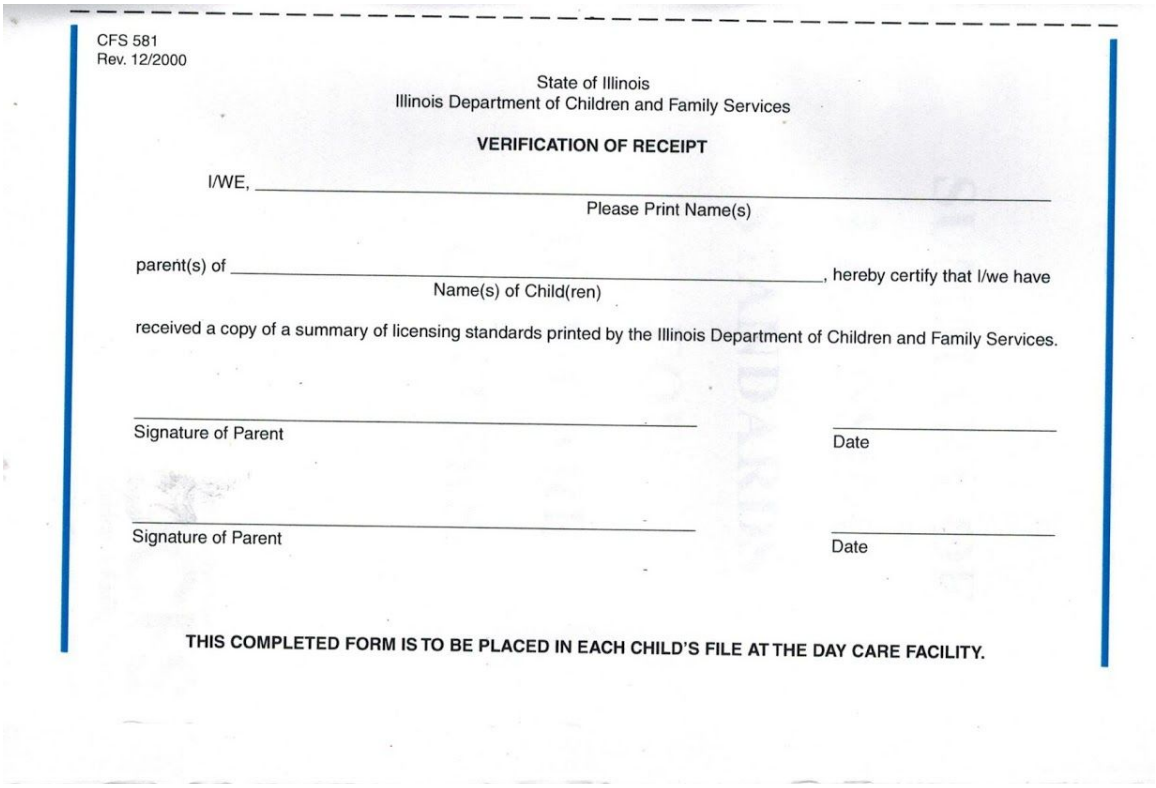
Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)

DCFS Licensing Standards Acknowledgment of Reciept

A link is provided for the DCFS Licensing Standards. Please review that document and then sign the form below.



CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.