

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

I am interested in (check all that apply): ☐ 5 Day ☐ 3 Day (M/W/F) ☐ 2 day (T/Th)

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 7:00 a.m. to 5:00 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/Instagram page, MCC website, or MCC publications, without compensation.

Tuition Payment Policies

As stated in our Parent Packet: Montessori Children's Centre offers a full-day, year-round program with 5-day, 3-day or 2-day options for three, four, and five-year-olds. Tuition is broken down into a weekly rate for our all day program. Please check with the director for current tuition rates. MCC will assess a \$50 materials and technology fee annually every October.

Annual tuition may be paid weekly, bi-weekly, monthly, or by the semester. Tuition payments may be made via 1Core, Montessori's online tuition payment system, which is withdrawn from your checking/savings account or credit card (a 2.5% fee is applied for credit card payments). Tuition may also be paid via cash, checks, or through your bank's on-line payment options. Payments of tuition over two weeks in arrears will be assessed \$10 per week. A fee of \$20 will be charged for bank returned checks, and a \$10 fee will be charged for declined or failed ACH/Credit Card transactions.

Because the programs at MCC are year-round, tuition is not credited for days missed by your child. Should you choose to take a vacation, it is your responsibility to continue tuition payments to MCC. 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, and you are unable to pay weekly with TAP (Tuition Auto Pay) or TPD (Tuition Pay Direct), 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:

_____ (Parent/guardian)

_____ (Parent/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.

The Montessori Children's Centre uses a 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 _____

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.



State of Illinois
Certificate of Child Health Examination

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



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 <i>after</i> 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)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT				
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> 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															
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) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella															
Lab Results Date MO DA YR (Attach copy of lab result)															

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
Date												Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R		L
Vision													
Hearing													

IL444-4737 (R-02-13)

(COMPLETE BOTH SIDES)

Printed by Authority of the State of Illinois

Last First Middle		Birth Date <small>Month/Day/Year</small>		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		Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No		Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No		Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No		TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No		Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No		Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.		
Eyes/Vision problems? <small>Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor</small>	Yes	No		Parent/Guardian Signature _____ Date _____		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Yes	No				
Ear/Hearing problems?	Yes	No				
Bone/Joint problem/injury/scoliosis?	Yes	No				
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA						
HEAD CIRCUMFERENCE if <23 years old		HEIGHT		WEIGHT		BMI B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI ≥ 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>						
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 <input type="checkbox"/> No <input type="checkbox"/>	Blood Test Indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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.						
Skin Test: Date Read		/ /	Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>	
Blood Test: Date Reported		/ /	Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		mm 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 <input type="checkbox"/> No <input type="checkbox"/>		Genito-Urinary	LMP	
Nose				Neurological		
Throat				Musculoskeletal		
Mouth/Dental				Spinal Exam		
Cardiovascular/HTN				Nutritional status		
Respiratory		<input type="checkbox"/> Diagnosis of Asthma		Mental Health		
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>	INTERSCHOLASTIC SPORTS		Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>	
Print Name _____		(MD, DO, APN, PA)	Signature _____		Date _____	
Address _____		Phone _____				

(Complete Both Sides)

DCFS Licensing Standards Acknowledgment of Receipt

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.