



Children's House of Miss Tammie Montessori School
5480 S. Kenwood Avenue
Chicago, Illinois 60615
Phone: (773) 329-8152

Enrollment Form

Parent or Guardian Info

First and Last Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Work _____ Cell _____

Email: _____

First and Last Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Work _____ Cell _____

Email: _____

Child's Information

Child's
Full Name: _____

Child's D.O.B: _____/_____/_____ Gender: Male Female

Medical Conditions: _____

Does Child Take Medications Daily for this Medical Condition? Yes No

If "Yes", What Medication(s)? _____

Food/Medicinal/Seasonal
Allergies: _____

Release Information

Please list the names of the individuals, other than yourself, who may drop off and pick up your child.

First/Last Name: _____

Contact #:(_____)_____ - _____ Relation to Child: _____

First/Last Name: _____

Contact#:(_____)_____ - _____ Relation to Child: _____

First/Last Name: _____

Contact#:(_____)_____ - _____ Relation to Child: _____

Emergency Contact Information

Please list the names of the individuals we may contact in an emergency situation in the event you can not be reached.

First/Last Name: _____

Contact #:(_____)_____ - _____ Relation to Child: _____

First/Last Name: _____

Contact#:(_____)_____ - _____ Relation to Child: _____

First/Last Name: _____

Contact#:(_____)_____ - _____ Relation to Child: _____

Emergency Medical Information

The following information will be used in the event of an emergency situation requiring an immediate decision be made by this facility regarding medical care for your child.

Preferred Hospital: _____

City, State, Zip Code: _____

Hospital Phone #:(_____)_____-_____

I give this facility permission to act on my behalf regarding emergency medical situations if I can not be reached. I prefer the facility to take my child to the above named hospital. I understand I will contacted immediately if such a situation arises.

Parent/Guardian Signature

Date

Pediatrician Information & Health Statement

Physician First/Last Name: _____

Physician's Clinic Name (If Applicable): _____

Address: _____

City, State, Zip Code: _____

Office Phone #:(_____)_____-_____

My child has had a well child check-up within the last twelve (12) months and is able to participate in this early childhood program.

Parent/Guardian Signature

Date

OR

My child has a scheduled well child check-up on ____/____/____. At that time, I will obtain a Health Statement from his/her pediatrician.

Parent/Guardian Signature

Date

Medication Authorization

Initial in the blanks below and sign in the designated area in acknowledgement of medication policies.

_____I understand that I must provide all medication to be administered to my child.

_____I understand that medications must be in their original container with manufacturer or physician instructions clearly labeled.

_____I understand that prescription medications shall be administered only to the child for whom the prescription is prescribed.

_____I understand that medications are not to be kept in the possession of my child; medications shall be turned in to the appropriate administrative staff of this facility.

_____I give this facility and it's staff permission to administer Tylenol and Motrin, or their generic counterparts, to my child. I further understand that if my child is under the age of two (2), I must submit a physician's note of authorization, including the proper dosage.

_____I will not hold the facility liable for any adverse reactions experienced by my child as a result of any medication for which I have authorized the administering of.

Parent/Guardian Signature

Date

Public School Information

Please provide the following information if your child attends Public School.

School Name: _____

Address: _____

City, State, Zip Code: _____

School Phone: (_____) _____ - _____ Grade: _____

My child's Vision/Hearing Screening Results are on file at his/her Public School. Yes No

My child's Immunization Records on file at his/her Public School. Yes No

I am enrolling my child in the following program: (Circle One)

Before School Only

After School Only

Before & After School

Policy Acknowledgement

Child's Name: _____

Start Date: _____

- 1. Deposit:** A deposit in the amount of \$_____ and a registration fee of \$_____ is required upon registration

- 2. Tuition Fees:** My families tuition rate is \$_____ per week. Tuition is due each Monday. If my child is attending on a "drop-in" basis, fees are due at the time of pick up.

- 3. Returned Checks:** I understand this center will re-deposit a returned check as a courtesy, however, there will be a **\$30.00 returned check charge** assessed each time the check is returned. Upon the second (2) returned check in a six (6) month period, cash or money order payments will be required for a six (6) month period.

- 4. Late Pick Up Fees:** I understand my account will be charged **\$2.00 for each minute after closing**, beginning at 5:46 p.m. Late fees are assessed regardless of circumstances. This also applies to illness-related pick ups (see "Illness")

- 5. Late Payment Fees:** I understand a **\$10.00** late fee will be assessed to tuition payments not received by Thursday morning. Also, a **service charge of 1 1/2 % per month** (18% APR) will be added to all overdue accounts also liable for all legal and collection fees.

- 6. Withdrawal Notice:** I understand that in order to withdraw my child's enrollment, **two (2) weeks written advance notice is required**. If I withdraw my child without giving two (2) weeks advance written notice, then I will be responsible for paying for two (2) weeks tuition after the last date of attendance.

- 7. Collection Fees:** I understand if a balance is maintained on my account, I will be notified of the balance. I will be given reasonable opportunity to dispute charges, if necessary. If payment, or payment arrangements are not made on undisputed charges, my account will be referred to the County Courthouse for collection. On the day paperwork is filed with the County Courthouse, my account will be charged a **collection fee of \$200.00 plus any postage fees** incurred during the entire collection process. In addition, I will be responsible for all applicable court costs.

- 8. Observed Holidays:** New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Thanksgiving Day After, Christmas Eve, and Christmas Day.

- 9. Illness:** I understand I may not bring my child to the facility if (s)he is ill. I will be notified if my child has to leave the center due to illness. I understand I have one (1) hour from the time of notice to pick up my child.

- 10. Absence/Vacation Policy:** So that we can maintain the highest quality of education and care for all children, **your child's tuition fees must be paid in full regardless of his/her attendance**. This policy applies to absences for any reason including illness, family vacation and center closings such as observed holidays and severe weather closings.

- 11. Acknowledgement:** I have received a copy of the current Parent Handbook of Facility Operational Policies & Procedures and understand by enrolling my child, I am agreeing to the terms set forth. I agree to keep a copy of the policies for future reference.

Director Signature

Date

Parent/Guardian Signature

Date