

Child's Name:								
			DANCE (5 Full days Mon	day-Friday)				
PROGRAM:	Toddler Roon	n (16-36 mos)	Casa Room ( 3-6 years)  Must be potty trained					
□ 5	Full Days	(9am-4:00pm)	☐ 5 Full Days	(9am-4:00pm)				
	5 Full Days Ext. (	(up to 10 hrs)	☐ 5 Full Days Ext.	(up to 10 hours)				
Hours Requ	uired: Dr	op Off:	Pick Up:					
9	SCHOOL AG	E ~ BUSSING PI	ROGRAM					
Name of C	Grade School		Bus #					
□ <u>Before</u>	& <u>After School</u> S	Supervision ONLY  MONDAY - F	RIDAY					
Parent	Drop Off:		Parent Pick Up:					
Bus Pic	k Up Time:		Bus Drop Off Time:					
□ Before :	School Supervis	sion ONLY						
		MONDAY - F	RIDAY					
Parent	Drop Off:		Bus Pick Up Time:					
□ After Sc	chool Supervisio	on ONLY						
		MONDAY - FI	RIDAY					
Paren	ł Pick Up:		Bus Drop Off Time:					



Date of Birth:	Gender:
Child's Last Name:	Child's First Name:
Child's Home Address (Inc. Postal Code)	Parent's Address (if different)
Home Phone Number:	
Mother/Guardian	Father/Guardian
Last Name:	
Employer's Name:	
Email Address	
Work Phone:	
Cell Phone:	

### **Custody Arrangements (if applicable)**

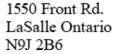
Are these custody arrangements pertaining to legal right of access to your child? YES NO If YES, please provide a copy of the appropriate legal documentation (eg., court order)



## **Emergency Contacts**

Full Name:	to child:
Primary Number:	Alternate Number:
Authorized to pick-up child	Relationship to child:
Primary Number:	Alternate Number:
☐ Authorized to pick-up child	
Pick Up Authorization  The following additional individuals are authorized confirm identity before child will be released)  Name &	d to pick up my child (Photo ID will be required to  Phone
Relationship:	Number:
Name & Relationship:	Phone Number:
requires additional support (e.g., Diabetes, f	/ special needs/ behavioural concerns that febral seizures, developmental delay, speechm, ADHD etc.)

If yes, an individualized plan for children with medical needs must be developed between the parent and the child care centre prior to the child's first day of care.





## **Allergy Information**

Does your child have a life-threatening allergy (e.g., anaphylactic to peanuts etc)
□ YES □ NO
If yes, an individual plan for an anaphylactic allergy that includes emergency procedures must be developed between the parent and the child care centre prior to the child's start date.
Does your child have any allergies that are not life-theatning (food or other substances ex. latex)?   YES   NO If yes, please provide relevant details, including what your child is allergic to, symptoms of a reaction and treatment required:
Dietary Requirements - If any dietary restrictions, please note you must bring in your childs lunch daily
Please list any dietary requirements/restrictions(e.g., vegetarian, gluten-free etc.)

#### **Immunization Record**

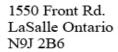
Please provide a copy of your child's immunization record (yellow card) to the centre prior to your child's first day. **PLEASE ATTACH A PHOTOCOPY OF YOUR CHILD'S IMMUNIZATION RECORD** 

If you have chosen not to immunize your child, a <u>Statement of Medical Exemption</u> form or <u>Statement of Conscious or Religious Belief</u> form must be completed, <u>notorized</u> and provided to the centre. These forms are available on the Ministry of Education's website.



## **Health Information**

Staff Name	Staff Signature	Date
Parent Name	Parent Signature	Date
<b>Additional Information</b> Please indicate any additional your child (e.g., prone to cold		
If yes, how long does ye	our child usually nap?	
Does your child nap?	☐ YES ☐ NO	
Sleep Arrangements		
If yes, an individual plan for ch between the parent and the		·
Does your child have any medical ADHD)?	need(s) that requires addition	nal support (e.g. Diabetes,
pox, measles etc.) please list t	•	
If your child has had any histor	ry of communicable dise	ases (e.g. chicken





## **EMERGENCY TREATMENT**

Parent's Name:	
Address:	
Phone Number:	
Cell Number:	
Health Card Numb	per:
	AUTHORIZATION FOR EMERGENCY TREATMENT
In case of a med	dical emergency, I understand that every effort will be made to contact the parents or guardians of:
	Name of Student - Please Print
	at I cannot be reached, I hearby give permission to the physician essori Early Years to hospitalize and/or secure proper treatment for my child.
Signature of Pare	ent/Guardian:
Date of Signature:	
ATTACH COPY OF	HEALTH CARD:



#### **NURSERY SCHOOL INFORMATION REQUEST**

All pupils entering school must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Varicella, and Meningococcal according to the *Immunization of School Pupils Act*, 2014. Exemptions to this requirement are for religious or conscience reasons (with affidavit), or medical reasons certified by a physician.

STUDENT INFO	DRM	ATI	ΟN	1								34		W	6	N	b	8		
Montessori Early Nursery School Name 177 Number	Yea	rs I	nc																	
Last/Family Name			1		1			Fi	rst Na	me								Mid	Idle Name	
O Male O Female								D	ate of	f Birtl	n (yy/	mm/	dd)					_		
Home Address					A	partn	nent #	# Ci	ty/To	wn								Post	Postal Code	
(optional) Health Card N	lumbe	er (10	digit	num	bero	only)	0.0	N	ame	(as sh	iown	on ca	rd)	(a)	y te	(5)				
Country of Origin/Birth			-12					N	ame (	of Far	nily [	octo	r		H	Ħ			Transaction .	
PARENT INFO	RMA	TIC	N																	
Name of Father/Guardia				è	-			1		Fat	her H	] - [ ome	Phor	- ne				Fath	ner Cell	
Name of Mother/Guard	ian									Mo	ther	] - [ Home	Pho	ne -				Mot	ther Cell	
										1410	ciic.	10111	21110					IVIO	ther cen	
Parent/Guardian Signat	ure		ш	L'					T									Date	e	
<b>STUDENT</b> IMM	UNI	ZAT	ΠΟΙ	N R	EC	QR[	)													
Date (yyyy-mm-dd)	Diphtheria	Tetanus	Pertussis	Polio (IPV)	Polio (OPV)	Hib (Haemophilus B)	Pneumo-conjugate-13	Rotavirus	Measles	Mumps	Rubella	Men-conjugate-C	Men-conjugate-ACYW	Varicella	Hepatitis B	Human Papillomavirus	Pneumo-poly	Other (please specify)	Vaccine brand name	
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#### MONTESSORI EARLY YEARS

# Participation Agreement to email and publish my child's work, photographs or videos via Lillio

To: Parent / Legal Guardian,

Please read this page carefully as it includes information about safety and security issues associated with privacy and behavior.

In the interest of safety and security we require parent permission for the publishing of children's work, photographs or videos through a software program called Lillio (the "Program"). By signing this form you grant permission for Montessori Early Years to photograph or video your child for the purposes of sharing this information with you through the Program. You will also receive updates and information about your child through the Program to the email you have provided herein.

MEY reserves the rights to all pictures taken and by signing this agreement you give rights to MEY to post pictures taken on MEY's website and social media. Note that sometimes other children in the center may feature in photos, videos or stories of your child. By giving your consent YOU agree not to share photos or video of any child, other than your own, outside the Program (All Social Media Sites). It is your responsibility to inform those who are under your Lillio profile and/or come in contact with the pictures about this. In the case that you do not adhere to these terms Montessori Early Years will immediately terminate your profile with Lillio.

To learn more about the Program, please visit www.lillio.com. Please complete, sign, and return this form to the center if you wish to participate. If you wish NOT to participate your child(ren) will only get reports and messages (no pictures). We encourage you to contact us if you have any questions. I hereby acknowledge that I wish to voluntarily participate in the Program:

Childs Name:	Date of Birth:	
Mother's Name:		
Email Address:		
Father's Name:		
Email Address:		
Signature:	Date:	
MEY Staff Initials:		



## **Parent Contract**

Please fill in and return with re-registration form Please check ( $\sqrt{}$ ) each after reading

	I have read and understand all of The Montessori Early Years Inc. Policies and Parent handbook including CWELCC guidelines etc: <b>available on the website</b> .
Due Andhers	and Dakit
Pre-Author	Payment to M.E.Y will be done on Pre-Authorized Debit. Please fill out/sign the Agreement form attached to the parent contract and <u>submit before the start date</u> . I understand that the payment will be posted for the 1 <sup>st</sup> of every month, and if starting in the middle of the month the first payment will be pro-rated and taken out on the start date.
	I understand that if there are extra services (not entitled to CWELCC rates), an invoice will be sent out and MEY will bill through the PAD.
	I will pay the \$75.00 registration fee/year on the first day of enrollment, this fee will be added to your first tuition payment. This registration fee is NON-REFUNDABLE in whole or in part.
	Any time taken off during the school year for vacation or other reasons is non-refundable
	All termination dates must be received 30 days in advanced.
	My child will be in <u>attendance</u> on a <u>full time</u> basis (5 days/week). I also understand that if my child misses his/her scheduled day, make up days will not be available.
	I will not send my child to school if she/he is ill. E.g.: Fever, Infectious diseases, vomiting, diarrhea, if they are too ill to participate in outdoor activities, or has a contagious illness. I also understand that my child must be fever free, diarrhea free and/or vomit free for <b>24 hours</b> before returning to school.
	If my child becomes ill at any time throughout the day at the school, I will come and pick him/her up immediately, or an alternative will.
	I have signed and returned the Lillio/MEY participation agreement; I understand that this is MEY's primary form of communication. If you decline the agreement, the onus will exclusively rely on the parent to obtain all school information.
	I understand that without this parent contract my registration will be null and void. This is a legal document.
Parent Name	: (Please Print) Parent Signature
	Date
School Admi	nistrator (Please Print) Administrator's Signature
	Data