

In order to complete your child’s registration please fill in all required fields and mail or drop-off at the school office with the following items:

1. Your child’s **original** birth certificate (clearly showing parent names) or other legal guardianship documents. *The school will copy the original documents and return them to you.*
2. A copy of your child’s most current immunization record.
3. A copy of your child’s latest two report cards and any other educational/specialist assessment reports/records.
4. Terms & Conditions of Enrolment – initial sections, sign & date document.
5. A non-refundable registration fee of \$1000.00 payable to Central Montessori Schools or CMS.
6. A non-refundable deposit equivalent to your monthly tuition. (This will pay the June 2024 tuition ONLY).
7. Nine post-dated cheques dated the 1<sup>st</sup> of each month (September to May) for monthly tuition owing.

**Please note that if items/information is missing - the application will be placed on “hold” until received.**

<b>PROPOSED STARTING DATE:</b> ____ (mm) ____ (dd) ____ (yy)	
<b>PROGRAM:</b>	
<input type="checkbox"/> <b>INFANT</b> (12 - 18 mths)	<input type="checkbox"/> 5 Full Days <input type="checkbox"/> 3 Full Days (M/W/F) <input type="checkbox"/> 2 Full Days (T/Th) <input type="checkbox"/> Extended Hours (5:00-6:00)
<input type="checkbox"/> <b>TODDLER</b> (18 - 30 mths)	<input type="checkbox"/> 5 Full Days <input type="checkbox"/> 3 Full Days (M/W/F) <input type="checkbox"/> 2 Full Days (T/Th) <input type="checkbox"/> Extended Hours (5:00-6:00)
<input type="checkbox"/> <b>CASA</b> (30 mths - 6 yrs)	<input type="checkbox"/> 5 Full Days <input type="checkbox"/> 5 Half Day ( <i>pickup at 11:45</i> ) <input type="checkbox"/> 5 Half Day ( <i>drop-off at 1:00</i> ) <input type="checkbox"/> Extended Hours (5:00-6:00) <input type="checkbox"/> Optional lunch for half day <input type="checkbox"/> Nap
<b>Approximate Drop-Off Time:</b> _____ <b>Pick-Up Time:</b> _____	

<b>CHILD’S INFORMATION:</b>		
Last Name:	Given Name(s):	
Date of Birth: ____ (mm) ____ (dd) ____ (yy)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Address:	City: Postal Code: Home Telephone Number:	
Languages Spoken at Home:		
Sibling Name(s):	Age(s):	Gender:
1.		
2.		
3.		
4.		

<b>MEDICAL INFORMATION:</b>	
Name of Child's Physician:	Physician's Address & Telephone Number:
Immunization is attached <input type="checkbox"/> Yes <input type="checkbox"/> No Reasons, if no: _____	
Please list child's allergies:	
Medication required <input type="checkbox"/> YES <input type="checkbox"/> NO	Name of medication:
Has your child ever shown signs of <b>Asthma</b> or <b>Seizure</b> (fever-induced or other):	Does your child have any history of Communicable Diseases / other Medical Conditions?
Does your child have any special dietary/ rest/ exercise requirements?	Does your child have any special physical, cognitive/ social or emotional needs?

<b>PARENT/GUARDIAN INFORMATION:</b>		
	<b>Parent 1:</b> Mother / Father / Guardian (please circle one)	<b>Parent 2:</b> Mother / Father / Guardian (please circle one)
Title (please circle)	Mr. Ms. Mrs. Dr. Other:	Mr. Ms. Mrs. Dr. Other:
Last Name		
First Name		
Address (if different from child)		
Home Number		
Cellular Number		
Email Address		
Employer Name		
Employer Address & Work Number		
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Common-law <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single	
Child lives with:	<input type="checkbox"/> Both Parents <input type="checkbox"/> Parent 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____	
Correspondence to be sent to:	<input type="checkbox"/> Both Parents <input type="checkbox"/> Parent 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____	

**EMERGENCY CONTACT AND PICK-UP PERSONS** *(other than parent/guardians):*

Full Name	Address & Telephone	Relationship to child	Pick-Up	Emergency Contact

I/We acknowledge that:

- Sixty days written notice, or payment in lieu of notice is required in the event of an early withdrawal from the school. Any post-dated cheques on file after that time will be returned.
- The initial deposit (last month's tuition fee & application/registration fee) presented at the time of registration, ***is non-refundable/transferable.***
- Tuition is based on enrolment (the space reserved for the child in the class) and no credit or refund is given for illness, vacation or non-attendance.
- I give consent to receive e-mails/ electronic communication from CMS.
- I have read and understand the CMS Parent Handbook (available at <https://cmschool.net/handbook-and-policies>) containing school policies & procedures.

Name of Parent or Guardian #1: \_\_\_\_\_ *(please print)*

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ *(mm/dd/yy)*

Name of Parent or Guardian #2: \_\_\_\_\_ *(please print)*

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ *(mm/dd/yy)*

*Central Montessori Schools welcome children regardless of race, religion, colour or creed.*

**THANK YOU FOR SELECTING CENTRAL MONTESSORI SCHOOL**

Once this application form is completed please mail or drop it off at the school office with **all** necessary items/ to:

**Central Montessori School**  
**72 Steeles Aves West, Thornhill, Ontario L4J 1A1, Tel: (905) 889-0012**

**Office use only:**

Application fee received: Yes [ ] No [ ] Date: \_\_\_\_\_

Deposit received: Yes [ ] No [ ] Date: \_\_\_\_\_

Post-Dated Cheques received: Yes [ ] No [ ] Date: \_\_\_\_\_

**Signature of Administrator:** \_\_\_\_\_

**Date of Withdrawal** \_\_\_\_\_ *(mm/dd/yy)*