

APPLICATION FORM



IvyCrest Montessori School Enrollment Application (Please Print)

CHILD'S LEGAL NAME: LAST _____ FIRST _____ MIDDLE _____

OTHER NAME BY WHICH CHILD IS KNOWN: LAST _____ FIRST _____ MIDDLE _____

HOME ADDRESS _____ CITY _____ ZIP _____

(_____) _____ - _____
HOME PHONE _____ MALE or FEMALE _____ AGE (YRS/MNTHS) _____ DATE OF BIRTH (MM/DD/YY) _____ PLACE OF BIRTH (STATE, COUNTRY) _____

CHILD'S SOCIAL SECURITY # _____ CHILD'S PRIMARY LANGUAGE: _____ LANGUAGE(S) SPOKEN AT HOME: _____

OFFICE USE ONLY:

ID#: _____

SCHOOL: _____ GRADE: _____

TEACHER: _____ RM #: _____

PROGRAM: _____

DATE ENROLLED: _____

REC RQST: _____ REC RCVD: _____

AGE VERIFICATION: _____

BIRTH CERT COPY/VERIFIED: _____

DATE ENTERED: _____ INITIALS: _____

APP FEE PAID: _____ LAST DAY ATTENDED: _____

CHILD LIVES WITH (CHECK ALL THAT APPLY): MOTHER FATHER GRANDPARENT STEPMOTHER STEPFATHER GUARDIAN CAREGIVER

PRIMARY SPONSOR'S NAME _____ HOME ADDRESS (STREET, CITY, STATE, ZIP) _____

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EXT. _____ E-MAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____ EMPLOYER'S ADDRESS _____

DRIVER'S LICENSE/CALIFORNIA ID _____ SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO CHILD _____ PRIMARY SPONSOR'S PLACE OF BIRTH (US STATE/COUNTRY) _____

SECONDARY SPONSOR'S NAME _____ HOME ADDRESS _____

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EXT. _____ E-MAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____ EMPLOYER'S ADDRESS _____

DRIVER'S LICENSE/CALIFORNIA ID _____ SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO CHILD _____ SECONDARY SPONSOR'S PLACE OF BIRTH (US STATE/COUNTRY) _____

PLEASE CHECK BOX IF CUSTODY IS SHARED WITH AN ALTERNATE SPONSOR: STEPMOTHER STEPFATHER GUARDIAN MOTHER FATHER GRANDPARENT

ALTERNATE SPONSOR'S NAME _____ HOME ADDRESS _____

(_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EXT. _____ E-MAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____ EMPLOYER'S ADDRESS _____

OTHER CHILDREN IN FAMILY (OLDEST TO YOUNGEST):

NAME	GENDER	DATE OF BIRTH	NAME OF SCHOOL	GRADE	HOME ADDRESS IF DIFFERENT
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PHOTOGRAPHIC AND INTERNET PERMISSIONS (INITIAL ITEM TO GIVE PERMISSION):

I APPROVE OF MY CHILD BEING PHOTOGRAPHED OR VIDEOTAPED FOR EDUCATIONAL PURPOSES, INCLUDING USAGE OF SUCH ON THE SCHOOL WEBSITE AND PUBLICITY. YES NO INITIALS _____

I GIVE IVYCREST PERMISSION TO ALLOW MY CHILD SUPERVISED ACCESS TO THE INTERNET FOR EDUCATIONAL PURPOSES YES NO INITIALS _____

PARENT DIRECTORY: WOULD YOU LIKE TO BE INCLUDED IN THE PARENT DIRECTORY? PLEASE CHECK AND INITIAL THE ITEMS YOU WANT LISTED IN THE DIRECTORY:

INCLUDE PRIMARY SPONSOR NAME YES NO INITIALS _____ INCLUDE SECONDARY SPONSOR NAME YES NO INITIALS _____

INCLUDE PRIMARY SPONSOR ADDRESS YES NO INITIALS _____ INCLUDE SECONDARY SPONSOR ADDRESS YES NO INITIALS _____

INCLUDE PRIMARY SPONSOR PHONE NUMBER YES NO INITIALS _____ INCLUDE SECONDARY SPONSOR PHONE NUMBER YES NO INITIALS _____

EMERGENCY MEDICAL TREATMENT CONSENT (PLEASE READ AND SIGN BELOW):

I (WE) THE UNDERSIGNED, PARENT(S) OF _____ A MINOR DO HEREBY AUTHORIZE IVYCREST MONTESSORI PRIVATE SCHOOL, ITS ADULT AGENTS AND EMPLOYEES, TO CONSENT TO ANY **EMERGENCY** X-RAY, EXAMINATION, ANESTHETIC, MEDICAL, DENTAL, OR ANY **EMERGENCY** SURGICAL DIAGNOSIS OR TREATMENT AND HOSPITAL CARE TO BE RENDERED TO SAID MINOR UNDER THE GENERAL OR SPECIAL SUPERVISION AND UPON ADVICE OF A PHYSICIAN AND/OR SURGEON LICENSED UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT OR DENTIST LICENSED UNDER THE PROVISIONS OF THE DENTAL PRACTICE ACT.

IT IS UNDERSTOOD THAT THIS AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC EMERGENCY DIAGNOSIS, TREATMENT OR HOSPITAL CARE BEING REQUIRED BUT IS GIVEN TO PROVIDE AUTHORITY AND POWER ON THE PART OF IVYCREST MONTESSORI PRIVATE SCHOOL, ITS ADULT AGENTS AND EMPLOYEES, TO GIVE SPECIFIC CONSENT TO ANY AND ALL SUCH EMERGENCY DIAGNOSIS, TREATMENT OR HOSPITAL CARE WHICH THE AFOREMENTIONED PHYSICIAN OR DENTIST IN THE EXERCISE OF HIS BEST JUDGMENT MAY DEEM ADVISABLE.

IT IS UNDERSTOOD THAT I (WE), THE PARENT(S), WILL ASSUME FINANCIAL RESPONSIBILITY FOR COSTS INCURRED FOR TREATMENT AND/OR HOSPITAL CARE.

THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISION OF SECTION 25.8 OF THE CIVIL CODE OF CALIFORNIA.

THIS AUTHORIZATION SHALL REMAIN EFFECTIVE AS LONG AS MY CHILD IS ENROLLED IN IVYCREST MONTESSORI PRIVATE SCHOOL.

DATE _____ NAME OF PHYSICIAN _____ (_____) _____ - _____ PRIMARY SPONSOR'S SIGNATURE _____
PHYSICIAN PHONE # _____

DATE _____ NAME OF DENTIST _____ (_____) _____ - _____ PRIMARY SPONSOR'S SIGNATURE _____
DENTIST PHONE # _____

DOES THE APPLICANT TAKE ANY **PRESCRIBED MEDICATION** OR NEED ANY SPECIAL MEDICAL ATTENTION? YES NO

IF YES, PLEASE EXPLAIN: _____

CONDITION: _____ MEDICATION: _____

CONDITION: _____ MEDICATION: _____

ALLERGIES (PLEASE LIST ALL OR "N/A"): _____

