



Contract for 2021- 2022 School Year Gig Harbor Campus

I am enrolling _____ (child's full name) _____ (DOB) in Arcadia Montessori School.

My child will be attending: 5 days/week ☐ 3 days/week ☐
School only ☐ School + Childcare ☐

I understand that I am responsible for tuition for nine months from September through June, to be paid in monthly installments of _____.

I understand that monthly tuition is to be paid on or before the first school day of each month, and that a \$10.00 late fee will be charged for each late payment.

Signature of Parent/Guardian

Date

Parent's Full Name(s): _____

Address: _____

Telephone Number(s): _____

Employer: _____

E-Mail Address: _____

Days and Hours of enrollment: _____

Expected Start Date: _____

Enclosed is the \$100.00 non-refundable registration fee ☐

Registration Form

Student's Name: _____
Last First Middle Nickname

Date of Birth: _____ Age: _____ Boy ☐ Girl ☐

Home Address: _____
Street City State Zip

Phone #'s: _____
Home Cell/Name Cell/Name

E-Mail Address: _____

Parent/Guardian: _____

Address: _____ Work Phone: _____

Employer: _____

Employer Address: _____

Parent/Guardian: _____

Address: _____ Work Phone: _____

Employer: _____

Employer Address: _____

Emergency Contacts:

1. _____
Name Phone # Address Relationship

2. _____
Name Phone # Address Relationship

Alternate Pickup List:

1. _____
Name Phone # Address Relationship

2. _____
Name Phone # Address Relationship



Information About Your Child:

1. Has your child ever attended another school or group setting? If so, where?
2. Does your child have any siblings? If so, what are their names and ages?
3. How does your child act when ill?
4. Does your child take naps? If so, what is an average nap time?
5. Is there anything else that we should know about your child?
6. Health Information:
 - A. How is your child's present health (i.e. any allergies, medications being taken, special needs)?
 - B. Does your child have any significant past health history (including common childhood diseases)?

Name of Physician: _____ Date of last physical exam: _____

Physician's Address: _____ Phone: _____

Name of Dentist: _____ Date of last dental exam: _____

Dentist's Address: _____ Phone: _____

☐ I have received a Parent Handbook and Disaster Policy and have had all policies explained to my satisfaction. (Available for download on our website)

Signature of Parent/Guardian

Date

CONSENT FOR EMERGENCY MEDICAL CARE

Child's Name: _____

I hereby grant Arcadia Montessori School permission to seek medical attention for my child in the event of an emergency and I am unable to be contacted.

I further consent to medical and surgical treatment by any licensed physician or hospital when deemed immediately necessary or advisable by the treating physician to safeguard my child's health if I am unable to be contacted. I waive my right of informed consent to such treatment.

I further authorize the removal and transportation of my child by ambulance or aid car to a hospital or emergency medical center for treatment.

I hereby agree to accept responsibility for any financial indebtedness incurred from the accident or during the hospitalization. I agree to pay for all necessary services at the current rate and, in case of collection, pay for all reasonable attorney fees and collection expenses.

YES ☐ NO ☐

Child's Physician: _____

Physician's Phone: _____

Hospital: _____

Medical Insurance Provider: _____

_____ Policy #: _____

Chronic Illnesses: _____

Regular Medications: _____

Date of Last Tetanus Shot: _____

Known Allergies (Drugs or other): _____

Parent/Guardian's Name: _____

Daytime Phone: _____

Parent Guardian's Name: _____ Daytime Phone: _____

Signature of Parent/Guardian

Date



Permission Form

Student's Name: _____

Phone and Email List:

We, the parents/guardians of the above named student, give permission to include the following information in the Arcadia Montessori School Phone and Email list to be distributed to all students.

Yes

☐

No

☐

Name(s): _____

Address: _____

Street

City

Zip

Phone Numbers: _____

Email Address: _____

Would you like your monthly newsletter and other school communications delivered electronically?

Yes ☐

No ☐

If Yes, what address(es) would you like to receive school communications at:

1. _____ 2. _____

Photographs and Video:

We, the parents/guardians of the above named student, give permission for photographs, movies, or video tapes including our child to be used for **internal school use**.

Yes ☐

No ☐

We, the parents/guardians of the above named student, give permission for photographs, movies, or video tapes including our child to be used for **publicity purposes**.

Yes ☐

No ☐

Signature of Parent/Guardian

Date



Supply List

Cubby Supplies:

1. Slippers
2. Rainboots
3. Change of Clothes
4. Small Plastic Cup

*Please remember to label all items with your child's full name!!

Earthquake Kit:

An earthquake/disaster kit is required. All items should fit in a one gallon ziploc bag and should be clearly labeled with your child's full name. The kit should include the following items:

- 1 family photograph
- A short note or card addressed to your child
- 3 small packages of juice
- 1 small box of cereal
- 1 small can of soup
- 2 small cans of fruit or vegetables
- 2 granola/energy bars
- 1 candy bar
- 1 small package of dried fruit/unsalted nuts/trail mix

Classroom Supplies:

A \$75.00 classroom supply fee is due before the start of school. This fee will be used to purchase basic supplies for each classroom (e.g. colored pencils, gluesticks, tissue). By collecting a fee instead of requiring each child to bring supplies we hope to: ease some of the burden of school preparation from our families, ensure that we receive the correct supplies, make the purchases more economical by buying in bulk and reduce the amount of packaging that we consume.

Please make out checks to: Arcadia Montessori School



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: First Name: Middle Initial: Birthdate (mm/dd/yyyy): Sex:

Symbols below: ♦ Required for School and Child Care/Preschool ♦ Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required Date

Reviewed by: Date: Signed Cert. of Exemption on file? ☐ Yes ☐ No

Vaccine	Dose	Month	Day	Year
♦ Hepatitis B (Hep B)	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens	1			
	2			
Rotavirus (RV1, RV5)	1			
	2			
	3			
♦ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)	1			
	2			
	3			
	4			
	5			
♦ Tetanus, Diphtheria, Pertussis (Tdap, Td)	1			
	2			
♦ Haemophilus influenzae type b (Hib)	1			
	2			
	3			
	4			
♦ Pneumococcal (PCV, PPSV)	1			
	2			
	3			
	4			

Vaccine	Dose	Month	Day	Year
♦ Polio (IPV, OPV)	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
♦ Measles, Mumps, Rubella (MMR)	1			
	2			
♦ Varicella (chickenpox) or verify disease 1-4	1			
	2			
Hepatitis A (Hep A)	1			
	2			
Meningococcal (MCV, MPSV)	1			
Human Papillomavirus (HPV)	1			
	2			
	3			
Office Use Only: Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	

If the child named on this CIS has had chickenpox disease (and not the vaccine), disease history must be verified. Mark option 1, 2, 3, OR 4 below – see, back #5.

1) ☐ Chickenpox disease verified by printout from CHILD Profile Immunization Registry. Must be marked by printout (not by hand) to be valid.

2) ☐ Chickenpox disease verified by Health Care Provider (HCP)

If you choose this box, mark 2A OR 2B below.

2A) ☐ Signed note from HCP attached OR

2B) ☐ HCP signed here and print name below:

Licensed health care provider (HCP) Signature Date (MD, DO, ND, PA, ARNP)

HCP Printed Name:

3) ☐ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry. If you choose this box, staff must initial that parent or guardian approves: (initial) (date)

4) ☐ Chickenpox disease verified by parent* If you choose this box, fill in the date or child's age when he or she had the disease: Age/Date of disease: *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box. Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. Signed lab report(s) MUST also be attached.

☐ Diphtheria	☐ Mumps	☐ Other:
☐ Hepatitis A	☐ Polio	
☐ Hepatitis B	☐ Rubella	
☐ Hib	☐ Tetanus	
☐ Measles	☐ Varicella	

Licensed health care provider (HCP) Signature Date (MD, DO, ND, PA, ARNP)

HCP Printed Name: