



Registration Package

To secure your spot, please send in the following

- One cheque dated today for \$150. This is a NON-refundable deposit. This is deducted from the first month's tuition.
- One cheque dated for the first of the month that you are starting less the \$150 deposit.
- Six post-dated cheques –for the monthly tuition.
- Cheques made payable to Fraser Heights Montessori
- The following forms completed

Child's Name: _____ Parent's Signature: _____

Email address _____

| | | |
|---|----------|--|
| <p><u>Montessori Daycare 7:30am-5:30pm</u> For 2, 3 and 4 day spots please indicate your preference in days. Tuesday/Wednesday/Thursday combination is not available.</p> | | |
| 5 days per week | \$725.00 | |
| 3 days per week | \$500.00 | |
| 2 days per week | \$350.00 | |
| <p><u>School Day 9:00am – 3:00pm</u></p> | | |
| 5 days per week | \$600.00 | |

#103 – 16814 104th Ave., Surrey, BC V4N 4L8 - 604-588-3455
fhmontessori@telus.net

www.fhmontessori.com

"I have seen the fee schedule and I accept its conditions and I apply to enroll my child in Fraser Heights Montessori."

Child's name:

Signed: _____ **Date:** _____
(parent)

Parent's Name: _____

Signed: _____
Date: _____ (Manager, Fraser Heights Montessori)

*The school may distribute a class list including phone numbers and addresses to the families for the purposes of play dates and carpooling.

*The school may photograph children during class time or special days to commemorate and to promote various educational or cultural events taking place.

*If you do not wish to be included on the class list or to have your child photographed, please inform us in writing.

The school reserves the right to request a child withdraw under (and not limited to) the following circumstances: continual late payment, child not adjusting to the environment, or family not adjusting to the school philosophy. Before being asked to withdraw, meetings and observations will be held with the parents to determine the most appropriate course of action.

One full month's written notice of withdrawal must be given before the month end prior to any child withdrawing from the school. If such notice is not given the following months tuition will be due.

Thank you for your interest in Fraser Heights Montessori!

Please copy for your records.

#103 – 16814 104th Ave., Surrey, BC V4N 4L8 – 604-588-3455

fhmontessori@telus.net

www.fhmontessori.com



Registration Form for Child Care

| | |
|---------------------|-------------------------------------|
| FACILITY NAME: | |
| FULL NAME OF CHILD: | USUAL NAME OF CHILD [IF DIFFERENT]: |

| Personal Information | | |
|------------------------------------|------------------------------------|----------------|
| CHILD'S DATE OF BIRTH: | GENDER: | STARTING DATE: |
| ADDRESS: | | POSTAL CODE: |
| | | PHONE: () |
| PARENT OR GUARDIAN: | PARENT OR GUARDIAN: | |
| ADDRESS [IF DIFFERENT FROM ABOVE]: | ADDRESS [IF DIFFERENT FROM ABOVE]: | |
| PHONE: | PHONE: | |
| WORK ADDRESS/ALTERNATE LOCATION: | WORK ADDRESS/ALTERNATE LOCATION: | |
| PHONE [INCLUDE LOCAL]: | PHONE [INCLUDE LOCAL]: | |
| CELLULAR/PAGER: | CELLULAR/PAGER: | |
| HOURS AT THIS LOCATION: | HOURS AT THIS LOCATION: | |

| Emergency Health Information | | | |
|------------------------------|--------|-----------------------------|--------|
| CARE CARD NUMBER: | | | |
| FAMILY DOCTOR/CLINIC NAME: | | FAMILY DENTIST/CLINIC NAME: | |
| ADDRESS: | PHONE: | ADDRESS: | PHONE: |

| |
|-----------------------------------|
| Consent for Emergency Care |
|-----------------------------------|

I authorize the staff at the child care centre to call a medical practitioner or ambulance in the case of accident or illness of my child(ren), if the parent cannot immediately be reached.

SIGNATURE OF PARENT/GUARDIAN:

DATE:

MANAGER OF FACILITY:

Person(s) Authorized to Pick Up Child
(other than parent/guardian listed above)

| | | |
|-------|---------------|--------|
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |

Persons(s) not Authorized to Pick Up Your Child

| | | |
|-------|---------------|--------|
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |

Custody Agreement:

YES

NO

IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE

ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY

| | | |
|-------|---------------|--------|
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |

Child's Immunization Status

(Please record dates [year/month/day] or attach copy of immunization)

IS YOUR CHILD UP TO DATE ON IMMUNZATIONS?

YES

NO

NOT IMMUNIZED

| DIPHTHERIA | PERTUSSIS | TETANUS | POLIO | MMR (Measles/Mumps/Rubella) | HIB |
|------------|-----------|---------|-------|--------------------------------|-----|
| 1. | 1. | 1. | 1. | 1. | 1. |
| 2. | 2. | 2. | 2. | 2. | 2. |
| 3. | 3. | 3. | 3. | | |
| 4. | 4. | 4. | 4. | | |
| 5. | 5. | 5. | 5. | | |

COMMENTS:

Health Information

[Please attach a separate sheet, if necessary]

REGULAR MEDICATION[S] AND REASONS FOR [PLEASE LIST]:

ALLERGIES AND TREATMENT OF [PLEASE LIST]:

INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S):

- a) Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc.)

- b) Please describe any concerns you may have regarding your child's development [i.e., behaviour, vision, hearing, speech, language, mobility, etc.]:

- c) Describe any specific care instruction regarding a) and/or b):

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

Group Experiences

WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES:

HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? YES NO

IF YES, HOW DID HE/SHE ADAPT?

HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN [E.G., SEEKS OTHERS OUT, FEELS SHY]:

Emotional

HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?

DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE:

WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?

General household Information

PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G., SIBLINGS, GRANDPARENTS, ETC.]:

PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:

PRIMARY LANGUAGE SPOKEN IN THE HOME:

OTHER LANGUAGES:

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

Facility Use Only

Staff person reviewing family's documents:

SIGNATURE:

PRINT NAME:

DATE:

CHILD'S WITHDRAWAL DATE:

REASON FOR WITHDRAWAL:

Any Other Comments