



# CMS

CENTRAL MONTESSORI SCHOOLS

## APPLICATION FOR ADMISSIONS: YORK MILLS CAMPUS

Proposed Entry Date: m/\_\_\_\_ d/\_\_\_\_ y/\_\_\_\_\_

**Infant Program:** (11 to 18 months)       **2 Full Days** (Tue & Thu)       **3 Full Days** (Mon, Wed & Fri)       **5 Full Days**

**Toddler Program:** (18 months to 3 yrs)       **2 Full Days** (Tue & Thu)       **3 Full Days** (Mon, Wed & Fri)       **5 Full Days**       **5 Half Days**

Extended Hours: (5:00 – 6:00 p.m.)    Yes     No

Approximate Drop-Off Time \_\_\_\_\_ Pick-Up Time \_\_\_\_\_

### CHILD'S INFORMATION

Child's Last Name			
Child's Given Names (underline name used)			
Date of Birth	Month	Day	Year
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>		
Home Address			
	City	Postal Code	
Home Telephone Number			
Name of Last School Attended			
Languages Spoken at Home			

## FAMILY INFORMATION

	<b>Mother/Guardian</b>	<b>Father/Guardian</b>
Title (Circle one)	Mrs. Ms. Dr. Other:	Mr. Dr. Other:
Last Name		
First Name		
Address (if different from child)		
Employer Name and Address		
Work Telephone Number		
Home Telephone Number		
Cell Telephone Number		
Email Address		
Marital Status	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Person with custodial rights: _____ <input type="checkbox"/> Custody papers available	
Applicant lives with	Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/>  Other _____	
Correspondence to be sent to	Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/>  Other _____	
Siblings Name(s)	Age(s)	Gender
1.		
2.		

## MEDICAL INFORMATION

Child's Health Card Number	
Name of Child's Physician	
Physician's Telephone Number	
Physician's Address	
Immunization is Attached	Yes <input type="checkbox"/> No <input type="checkbox"/> Reasons, if no _____
List Child's Allergies	
Does your child have any special dietary requirements?	
Does your child have any special physical, cognitive/ social or emotional needs?	

## EMERGENCY AND CHILD PICK-UP INFORMATION

Name of contact person in the event of an <b>emergency</b> :		
Name	Telephone	Relationship
Other people allowed to <b>pick-up child</b> from the school:		
Name	Telephone	Relationship

In order for your child's application to be processed it is necessary to include the following items:

1. A copy of your child's birth certificate (record of Landing/Passport).
2. A copy of your child's latest report and any other educational assessment reports.
3. A non-refundable deposit equivalent to your monthly tuition. (This will pay the June 2009 tuition ONLY).
4. A non-refundable application fee of \$250.00 payable to Central Montessori Schools.
5. 9 post-dated cheques dated September 1, 2008 to May 1, 2009.

Note: Sixty days written notice is required in the event of an early withdrawal from the School and at this time, the school will return any post-dated cheques on file.

Please complete this application form and mail or drop it off at the school with all necessary items in the enclosed envelope to:

Central Montessori School  
18 Coldwater Road  
North York, ON M3B 1Y7

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

Name of Parent or Guardian: \_\_\_\_\_  
(Please print)

\_\_\_\_\_  
Date (month/day/year)

\_\_\_\_\_  
Parent or Guardian Signature

**THANK YOU FOR SELECTING CENTRAL MONTESSORI SCHOOLS**

**Office use only:**

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

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

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

**Date of Withdrawal**

\_\_\_\_\_  
m/\_\_\_\_\_ d/\_\_\_\_\_ y/\_\_\_\_\_

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