



## Registration Form

### Registration Procedure

- Registration fee of \$ 500 non-refundable and non-transferable
- Registration Fee of \$250 for Subsequent siblings in family if applicable
- Come visit us with your child "1st visit" (maximum 2 adults) **Mandatory**
- Submit this form along with Registration fee(s)

### Enrollment

School Administration will notify you 30 days prior to the Enrollment date. If you wish to accept you are required to visit the school and bring the following:

- Deposit fee (one month).
- Submit a copy of immunization records
- Review and sign all school forms and policies.

Place your  
child's  
current  
photo

We will make every effort to fulfill the requested enrollment date; however this date is subject to school availability and is not guaranteed. To guarantee enrollment we must receive the required deposit fee along with a signed copy of all documents provided at that time. Failure to meet these requirements will be considered withdrawn of application. If you wish to not accept the proposed date we will provide you with one more additional date at a later time. Registration fee will not be returned at any time. Deposit is non-refundable and non-transferable. Upon enrollment Deposit fee can be used toward the last month's tuition upon receiving a 60 days written notifications of withdrawal. Make cheques payable to: **Galaxy Montessori**

### Child Information

Last Name:		First Name:		Middle Initial:	
Date of Birth: (YYYY/MM/DD)	Gender: <input type="checkbox"/> Girl <input type="checkbox"/> Boy	Potty Trained: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Home Address:			City:		
Province: <b>ON</b>	Postal Code: ____-____	Home Phone: ( ) ____-____			
Child lives with	<input type="checkbox"/> Mother & Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other _____	
Siblings: #	Name: <i>First name</i>	Age:	Name: <i>First name</i>	Age:	

### Program Registration

Requested Enrollment Date: <i>DD-MM-YY</i>	<i>(Requested Enrollment date is not guaranteed until confirmed by school administration)</i>	
<input type="checkbox"/> Pre-Casa (18 months – 3 years)	}	<input type="checkbox"/> Full Time (Full curriculum included)
<input type="checkbox"/> Casa 1 Program (3 – 4 ½ years)		
<input type="checkbox"/> Casa 2 Program (4 - 6 years)		
Drop off Window:	<input type="checkbox"/> 7:00 AM – 8:00 AM	Pick up Windows:
	<input type="checkbox"/> 8:00 AM – 9:00 AM	<input type="checkbox"/> 3:00 PM – 4:00 PM
	<input type="checkbox"/> Other : _____	<input type="checkbox"/> 4:00 PM – 5:00PM
		<input type="checkbox"/> 5:00 PM – 6:00 PM

### Emergency Contact Person: (Please provide two contact other than parents or legal guardians)

Full Name:		Full Name:	
Relationship to child:		Relationship to child:	
Home Tel: ( ) ____-____	Cell: ( ) ____-____	Home Tel: ( ) ____-____	Cell: ( ) ____-
Home Address:		Home Address:	

Parent Access ID: \_\_\_\_\_

Student ID: \_\_\_\_\_

Finish Date \_\_\_\_\_

## Parent Information

<b>Mother / Legal Guardian</b>	Last Name:		Mother's First Name:		
	Home Address: <i>(only if different from child)</i>				
	City:		Province: <b>ON</b>	Postal Code: ___-___	
	Home Phone: ( ) ___-___		Cell: ( ) ___-___	Work: ( ) ___-___ EXT:	
	Email address:			<input type="checkbox"/> Send me school updates electronically	
	Employer's Name:			Occupation:	
	Work Address:		City:	Province:	Postal Code: ___-___

<b>Father / Legal Guardian</b>	Last Name:		Father's First Name:		
	Home Address: <i>(only if different from child)</i>				
	City:		Province: <b>ON</b>	Postal Code: ___-___	
	Home Phone: ( ) ___-___		Cell: ( ) ___-___	Work: ( ) ___-___ EXT:	
	Email address:			<input type="checkbox"/> Send me school updates electronically	
	Employer's Name:			Occupation:	
	Work Address:		City:	Province:	Postal Code: ___-___

## Authorized People to Pick up the Child *(other than parents, Photo ID required)*

Name:	Name:
Relationship to child:	Relationship to child:

## Medical Information

Family Doctor Last name: <b>Dr.</b>	First	Phone: ( ) ___-___
Address:	City	Province: <b>ON</b> Postal Code: ___-___

Medical History: Please indicate any medical history and complication for your child

Condition	Details		
<input type="checkbox"/> Communicable Diseases			
<input type="checkbox"/> Dietary Restrictions	1 )	2 )	3 )
<input type="checkbox"/> Other	1 )	2 )	3 )
<b>Allergies: (Name all)</b>	1 )	2 )	3 )

Does your child require an Epi-Pen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What is the allergen
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## List of Symptoms if the Child is ill

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## Instructions for rest & exercise

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Parent Signature \_\_\_\_\_

Date : \_\_\_\_\_

School Principal / Supervisor Signature \_\_\_\_\_

Date: \_\_\_\_\_