AMERICAN montessori ACADEMY

**Early Childhood PROGRAM**

# 2018-2019 Enrollment Application

_____ **Tuition**

_____ **Date App. Fee Paid Cash or Check**

_____ **GSRP**

**Student's Name**:_____
Last First Middle

**Birth Date**:_____/____/_____**Place of Birth**:_____ ◯ **Male** ◯ **Female**

**Address**:_____ **Apt. #** _____ **Complex:**

**City and Zip**:_____**Home Telephone:**_____

**Email Address:**_____**Cell Telephone:** _____

**Racial/Ethnic Background:** Is this student Hispanic/Latino?_____Yes _____No

____American Indian/Alaska _____White/Caucasian _____Hispanic/Latino

____Black/African American _____Asian _____Native Hawaiian / Pacific Islander

**Language spoken in your home:**_____ **Is student an immigrant?** _____

**Student's primary language:**_____ **Is student a refugee?** _____

## Family Information

**Mother's Name**:_____
Last First Middle Initial

Education (highest grade completed or degree): _____

Occupation:_____ ◯ Full time ◯ Part time

**Father's Name**: _____
Last First Middle Initial

Education (highest grade completed or degree): _____ Occupation:_____

◯ Full time ◯ Part time

Child lives with: ◯ Both Parents ◯ Mother ◯ Father

◯ Legal Guardian ◯ Other

**Years at current address:** _____ **Years at Previous Address:** _____

**List all *other* children in the home:**

| NAME | BIRTHDATE | RELATIONSHIP TO CHILD | SCHOOL ATTENDING |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**List all *other* adults in the home:**

| NAME | RELATIONSHIP TO CHILD |
|---|---|
| | |
| | |
| | |

**Briefly state any concerns you have in the following areas:**

**Child Health/Development:**

_____

**Housing/Community/Financial Factors:**

_____

**Parenting/Family:**

_____

***Certification: I certify that I have provided information which is true and accurate to the best of my knowledge. I agree to notify the school of address and/or telephone number changes. I understand that all information contained in this application is confidential. If my child is eligible for Head Start, I will be referred to the program for enrollment information.***

**Parent/Guardian Signature:_____Date:**

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## FOR SCHOOL/OFFICE USE ONLY

**REQUIRED INFORMATION COLLECTED**:

◯ **Birth Certificate** ◯ **Immunization** ◯ **Recent Physical**

◯ **Residency** ◯ **Income Verification**

**Income Eligible**: **YES** **NO** **FAMILY SIZE**:

**Risk Factors**: #_____#_____ #_____ #

**IEP? NO** **YES** **LAST IEP**

**Eligibility area(s):_____Family services received: _____**

**Program Staff Signature: _____**

# Parent or Guardian: Please fill out all sections

## SECTION I. MEDICAL HISTORY

**Has your child ever had the condition or disease listed below? (U = Unknown)**

| | Yes | No | U | | Yes | No | U | | Yes | No | U |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | | | | Chicken Pox | | | | Ear Infections | | | |
| Cancer | | | | Frequent Colds | | | | Eye Infections | | | |
| Pneumonia | | | | Sickle Cell Trait | | | | Heart Disease | | | |
| Seizures | | | | Sickle Cell Disease | | | | Liver Disease | | | |
| Diabetes | | | | Strep Infections | | | | Kidney Disease | | | |

*If you checked "Yes" to any of the conditions listed above, please explain:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Has child been hospitalized, had an operation, or have a serious illness? If yes, please explain: | | | Have there been any recent changes in your child's life (death, divorce, illness, separation)? If yes, please explain: | | |
| Does Child Have: | | | Does child have allergies? ◯ Yes ◯ No Please list them: | | |
| Frequent sore throats | | | | | |
| Frequent cough | | | | | |
| Urinary infections | | | What happens during an allergy attack? | | |
| Stomach Pain | | | | | |
| Vomiting | | | Is child taking medicine now? ◯ Yes ◯ No | | |
| Diarrhea | | | Name of medicine(s): Reason: | | |
| Constipation | | | 1. 1. | | |
| Does child have difficulty seeing? | | | 2. 2. | | |
| Does child wear glasses? | | | 3. 3. | | |
| Does child have problems with ears or hearing? Please explain: | | | Does your child go to the doctor more than five times a year? | | |
| Do you have any additional concerns or worries about your child? Please explain: | | | | | |

## SECTION II. PREGNANCY/BIRTH HISTORY

What was the child's weight at birth?_____ What was mother's age at ***first*** pregnancy?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Did mother have a health problem affecting the baby during the pregnancy or delivery? Please Explain: | | | Did mother take medication during pregnancy? Medicine/reason: | | |
| | | | Drugs? | | |
| | | | Alcohol? | | |
| Was child born more than three weeks: ◯ Early? ◯ Late? | | | Were there any health problems at birth? Please Explain: | | |

## SECTION III. DENTAL HISTORY

| | Yes | No | |
|---|---|---|---|
| Does the child have any trouble with teeth, gums or mouth? | | | If yes, please explain: |
| Has child seen a dentist? | | | Dentist's Name? |

## SECTION IV. DEVELOPMENTAL HISTORY

| At what age did your child talk? | | | At what age did your child walk? | | |
|---|---|---|---|---|---|
| | Yes | No | | Yes | No |
| Does your child put three words together in a sentence? | | | Which hand does your child use most often? ◯Left ◯ Right | | |
| Are you able to understand your child at least half of the time? | | | Does your child tell you in words what he/she wants and needs? | | |
| Has your child ever had trouble walking, climbing, reaching, holding on to things? Please Explain: | | | Does your child play with blocks, boxes, cups, or other construction toys without help? | | |
| Can your child: Run?_____Jump?_____Toss/catch? | | | Does your child have any pets? What kind of pets? | | |
| Does your child use crayons and/or markers to scribble or draw? | | | How many hours a day does your child spend watching TV? | | |
| Does your child turn pages of a book and look at pictures? | | | Do you have any concerns about your child's play or social experiences? Please explain: | | |
| Does your child listen to stories being read? | | | Does your child eat or chew on non-food things? Please explain: | | |
| Does your child recall stories or events? | | | Does your child have any food restrictions for medical or religious reasons? Please explain: | | |
| Does your child talk with your friends/relatives who come to visit? | | | Does your child drink from a bottle? ◯ at bedtime | | |
| Does your child enjoy playing alone or with imaginary friends? | | | Has your child had any recent changes in appetite? | | |
| Does your child follow simple, Age-appropriate directions? | | | Does your child have any food she dislikes? Please list: | | |
| Has your child participated in any group experiences?(i.e., preschool, daycare) Please explain: | | | Does your child have favorite foods? Please list: | | |
| What are your child's favorite toys, activities, books? | | | Is your child able to feed himself? | | |
| Does your child worry a lot or is afraid of anything? Please explain: | | | Does your child have special dietary needs? Please explain: | | |
| Do you give your child vitamins? What kind? | | | Does your child have trouble chewing or swallowing? | | |
| Does your child sleep less than eight hours a day or have trouble sleeping (such as a nightmare, anxiety, or wants to stay up late)? | | | Is your child trained for: Bowel?_____Bladder? | | |
| Does your child take a nap? | | | How does your child let you know he needs to use the bathroom? | | |
| What time does your child go to bed at night? | | | Is the student's parent or guardian currently on active duty for any branch of the military? If so, which branch: _____ | | |
| Has your child attended any type of day care or preschool program prior to AMA? ◯ Yes ◯ No<br>What was the name of the school/program? | | | If your child has attended a day care or preschool program in the past, what were your thoughts about the program? | | |