

The Montessori School of Camden

Enrollment Record

Child's full name _____ Nickname _____ Birth date _____ Age _____
 Address _____ Phone _____

City _____ State _____ Zip _____

Health Insurance Co. _____ Policy Holder's Name _____
 Policy # _____ Physician's Name _____ Physician's # _____

Health Information including limitations, allergies, asthma, diabetes, epilepsy and regular medication:

I certify that to the best of my knowledge _____ is in good mental and physical health and able to participate in the child day care program at The Montessori School of Camden. Certificate of Immunization or waiver must be on file.
Best Emergency Contact Number _____

Signature of parent or guardian _____ date _____

PERSONAL RECORD

FATHER

MOTHER

Name: _____ Address: _____ City, State, Zip: _____ Place of Employment: _____ Occupation: _____ Home phone: _____ Cell phone: _____ Work phone: _____ Email address: _____	Name: _____ Address: _____ City, State, Zip: _____ Place of Employment: _____ Occupation: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email address: _____
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No child will be allowed to leave the school with anyone except parents without written permission from parent. Please allow 48 hours notice for changes to authorized pick-up list.

Names of persons authorized to pick up child or to be contacted in an emergency if parents cannot be reached:

(Please attach a photocopy of a driver's license for all persons on the pick-up list)

Name _____
 Phone _____
 Address _____
 Relationship _____

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