



## REGISTRATION FORM 20 / 20

(Please PRINT information CLEARLY and complete ALL fields.)

**Child's Full Name:** \_\_\_\_\_  
First Middle Last

Birth date: \_\_\_\_\_ Gender: M F Primary Contact #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip code

Father/Guardian E-Mail: \_\_\_\_\_

Mother/Guardian E-Mail: \_\_\_\_\_

### **\*PARENT/GUARDIAN INFORMATION\***

**Father/Guardian:** \_\_\_\_\_

Home Address: (If different from child's)

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip code

Home Phone: \_\_\_\_\_

Place Employed: \_\_\_\_\_

Work Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip code

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Mother/Guardian:** \_\_\_\_\_

Home Address: (If different from child's)

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip code

Home Phone: \_\_\_\_\_

Place Employed: \_\_\_\_\_

Work Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip code

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

### **PERSONS AUTHORIZED TO PICK UP CHILD**

(List person(s) other than parents permitted to pick up.)

1. \_\_\_\_\_  
Full Name Contact #

2. \_\_\_\_\_  
Full Name Contact #

3. \_\_\_\_\_  
Full Name Contact #

#### **OFFICE USE ONLY**

Application/Registration Fee/s: \_\_\_\_\_ Date Received: \_\_\_\_\_ Deposit (\$250) Received \_\_\_\_\_

Teacher: \_\_\_\_\_ Start Date: \_\_\_\_\_ Exit Date: \_\_\_\_\_ Deposit Applied to \_\_\_\_\_  
Month/Year

**EMERGENCY CONTACTS**

**(Non Parent/Guardian)**

List the names and contact details of 2 people who will assume temporary care of your child if you cannot be reached, or will know where to reach you. Must be within one hour access of school.

**#1. Name:** \_\_\_\_\_ **Contact #:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

**#2. Name:** \_\_\_\_\_ **Contact #:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

**HEALTH INFORMATION & EMERGENCY TREATMENT**

I \_\_\_\_\_, ( Mother  Father  Legal Guardian)do, hereby voluntarily authorize St. Mark's Montessori School(SMMS) staff to seek medical treatment for my son/ daughter as they see necessary at an INOVA medical center or any other nearby facility. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide SMMS administration the authority to seek medical treatment for my child, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary.

It is understood that while SMMS makes an effort to secure quality emergency medical care for the student, the School, its trustees, officers, employees or agents, are not responsible for any harm to the student which results from the negligence of third parties in providing such care. It is understood that the School will attempt to communicate immediately with the student's parent or guardian to inform them of emergency measures. However, such communication is not pre-condition to the permission and authorization hereby above extended to the authorities of SMMS to secure emergency medical treatment for the student.

I accept full responsibility for payment of all services rendered and authorize any medical facility which renders service to release medical information necessary for the processing of insurance claims.

_____	_____	_____
<b>Signature of Parent/ Guardian</b>	<b>Print Name</b>	<b>Date</b>
_____	_____	_____
<b>Signature of Parent/ Guardian</b>	<b>Print Name</b>	<b>Date</b>

Medicines Child Taking \_\_\_\_\_

Outstanding Medical History (ex. Diabetes, heart disease, etc.) \_\_\_\_\_

Does your child have any allergies? If yes, please explain. \_\_\_\_\_

Does your child have any food restrictions? If yes, please explain. \_\_\_\_\_  
(Must be accompanied with doctor's letter, when not allowed to eat/drink school supplied food)

Does your child have any chronic ailments/problem? If yes, please explain. \_\_\_\_\_

Actions to be taken: \_\_\_\_\_  
(Chronic ailments requiring medication must be accompanied with proper documentation)

**Child's Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip code

## TUITION AND BAC PAYMENTS

Payments are made one month in advance, and due by the 5<sup>th</sup> of the month. \$25.00 late fee will be applied after the 5th of the month for each month

Tuition Payments	Due On The 1st of	3 & 4 year olds	Kindergarten
<b>\$100.00 Non Refundable School Re-registration Fee.</b> (Waived for Church member or 2nd sibling in our school in the same year)			
<b>Monthly (x 10)</b>	<b>August- May</b>	<b>\$510.00</b>	<b>\$588.00</b>
Semester (x 2)	August & January	<b>\$2,448.00</b>	\$2,822.00
Annual	August	<b>\$4,845.00</b>	\$5,586.00
Materials Fee	Due On The 1st of		
Semester (x 2)	August & January	<b>\$20.00</b>	\$30.00
Annual	August	<b>\$40.00</b>	\$60.00
BAC Monthly Payments	Due on the 1st of the month (August - May)		
<b>\$100.00 Non Refundable BAC Registration Fee.</b> (Waived for Church member or 2nd sibling in our school in the same year)			
<b>Before Care *</b>	(M-F) 7:30-9:00	<b>\$200.00</b>	\$200.00
<b>After Care *</b>	(M-F) 12:00-6:00	<b>\$530.00</b>	
	(M-Th) 3:00-6:00 (F) 12:00- 6:00		\$452.00
<b>Before &amp; After Care</b>	(M-F) 7:30-9:00 12:00-6:00	<b>\$585.00</b>	
	(M-Th) 7:30-9:00 3:00-6:00 (Fri: 12:00- 6:00)		\$507.00
<b>Extended Care</b> for Siblings of Kindergartners *	(M-Th) 12:00 -3:00 on days when afternoon Kindergarten is in session.	<b>\$250.00</b>	

\*Not eligible to attend on Day Care Only days.

**PM Plans:** Day Care is available from 9:00 – 6:00pm on Day Care only days.

## PHOTOGRAPHY

Please check a box.

I grant SMMS the right to take photographs of my child/children in connection with the SMMS program. I authorize SMMS, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that SMMS may use such photographs of my child/children, without any personal identifiers, for lawful purposes, including for example such purposes as publicity, illustration, advertising, and Web content.

I **do not** grant SMMS the right to take photographs of my child/children.

## DIRECTORY

We issue a school directory each year. The directory contains the parents' names, phone number, email address, the child's name and classroom. The purpose of the directory is to facilitate friendships, car pool arrangements, play dates among the children, birthday parties, and other activities. Please remember that the use of the directory for business or other purposes is inappropriate.

**Opt Out:** Check box if you do not wish to be listed in the directory.

Your signature below indicates that you have received our Parent Information Booklet and understand the policies and procedures of SMMS.

I have read and understand the policies and procedures in the Parent Handbook. I agree to abide by them.

1. \_\_\_\_\_ (Signature of Parent/Guardian) \_\_\_\_\_ (PRINT name of Parent/Guardian) \_\_\_\_\_ Date

2. \_\_\_\_\_ (Signature of Parent/Guardian) \_\_\_\_\_ (PRINT name of Parent/Guardian) \_\_\_\_\_ Date

\_\_\_\_\_  
Director Name Kathy Flynn Date \_\_\_\_\_