1613 Great Falls St., Suite 101B
McLean, VA 22101

703.356.4691
www.LewMontessori.school

LEWINSVILLE MONTESSORI

Enrollment Application Form

Child's Name: _____ Today's Date: ___ / ___ / ___

Child's Nickname: _____ Start Date: ___ / ___ / ___ (space permitting)

Date of Birth:___ / ___ / ___ Registration Fee _____

Male _____ Female _____ Security Deposit Fee_____

Father/Guardian Information:

Name: _____ Home Phone #: _____
Cell Phone #: _____ Work Phone #: _____
Home Address: _____ City: _____ State/Zip: _____
Occupation: _____ Company: _____
Work Address: _____ City: _____ State/Zip: _____
E-Mail Address: _____

Mother/Guardian Information:

Name: _____ Home Phone #: _____
Cell Phone #: _____ Work Phone #: _____
Home Address: _____ City: _____ State/Zip: _____
Occupation: _____ Company: _____
Work Address: _____ City: _____ State/Zip: _____
E-Mail Address: _____

**Please note, parental information must match that of the birth certificate unless a legal custody agreement is in place and provided to the Lewinsville Montessori School Administration.*

Siblings:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

How did you hear about Lewinsville Montessori School?

☐ Website/Internet ☐ Advertisement ☐ Friend/Referral_____ (name)

Has your child previously attended a Montessori school? Please circle Yes No
School Name/Location: _____
Why did you change schools? _____

Has your child previously attended a Preschool or DayCare? Please circle Yes No
School Name/Location: _____
Why did you change schools? _____

Please give any information concerning your child which will be helpful in his/her experience in group setting (such as play, eating and sleeping habits, special fears, special likes or likes or dislikes):

_____

_____

_____

Does your child have any developmental delays that you are aware of?

_____

Does your child have any known allergies: No____ Yes____

If yes, please list: _____

Does your child presently take any medications: No____ Yes____

If yes, please list: _____

Note: If any medications are taken for 10 or more days, a Medication Authorization MUST also be completed and on file.*
**The ONLY medications that we are allowed to administer/dispense are Epipen (and Benadryl if prescribed together), Nebulizer, and Ranitidine.*

I authorize the following people to pick up or drop off my child as well as to be contacted in the event of an emergency if the parent/guardians cannot be reached. Identification will be required at time of pickup. **Two** people must be listed and must live at separate addresses. **One of them must be local. This information must be filled out completely.**

Name: Home Phone #:
Cell Phone #: Work Phone #:
Home Address: City: State/Zip:
Relation to child:

Name: Home Phone #:
Cell Phone #: Work Phone #:
Home Address: City: State/Zip:
Relation to child:

Identity Verification: (Staff Use Only)

Birth Certificate Number: _____ Birth Date:____ / ____/ ____
Place of Birth: _____ Date Issued: ____ / ____ / ____
Date Document Viewed: ____ / ____ / ____ Person Viewing the Document: _____
Other Form of Proof:
_____

Date of notification of Local Law-Enforcement Agency (when required proof of identity is not provided): _____
Date

Proof of the child's identity may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies).