CORAL SPRINGS MONTESSORI
ENROLLMENT FORM

Last 4 digits of Mom's SS# (needed for PIN #) ________________ Start Date_______

Child's Name____
Pick-up time (12,3,4,5, or 6)__________
Days of week: Mon___Tue___Wed___Thu___Fri___

Address____
street city state zip
Birth Date__________________ Gender________Preferred Name___________________

Mother's Name____________________________________(or guardian) Email Address______________________

Home Address____
Street city state zip
Home Telephone______________________mobile phone___________________________

Father's Name_______________________________________(or guardian) Email Address______________________

Address____
Street city state zip
Home Telephone_______________________mobile phone__________________________

Father or Guardian's Employment____
Work Address____Telephone___________
street city state zip
Mother's or Guardian's Employment____
Work Address____Telephone___________
street city state zip

Child's Physician______________________________
Physician Address and Phone Number____
May the center contact another physician if unable to contact the above?______________
Responsible Party for medical bills____
Insurance Company Name___________________________Phone____________________
Insured ID Number____________________________

Other persons to notify and remove child in case of illness or accident (2 names required)

1. Name_____________________________relationship to child_______________________
Address and phone____
2. Name_____________________________relationship to child_______________________
Address and phone____

Persons permitted to remove child

Mother yes__no__Father yes__no__

1.Name_____________________________relationship to child_______________________
Address and phone____
2. Name___________________________relationship to child________________________
Address and phone____

Signature of person enrolling child________________________________ Date__________