Casa dei Bambini

Montessori Children's Center

CHILD'S NAME (LAST, FIRST) _____ NICKNAME _____ AGE _____

BIRTHDAY _____

PREVIOUS PROGRAM PARTICIPATION

HAS YOUR CHILD ATTENDED A MONTESSORI PROGRAM BEFORE? _____

HOW LONG DID S/HE PARTICIPATE IN A MONTESSORI PROGRAM? _____

HAS YOUR CHILD ATTENDED ANY OTHER PROGRAM(S)? _____

HOW LONG DID S/HE PARTICIPATE IN THIS PROGRAM(S)? _____

ANY DETAILS YOU WISH TO SHARE: _____

MEDICAL HISTORY

DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES? _____

PLEASE DETAIL ALLERGIES/TREATMENT: _____

DOES YOUR CHILD HAVE ANY OTHER SPECIAL MEDICAL CONDITIONS: _____

PLEASE EXPLAIN: _____

DOES YOUR CHILD HAVE ANY CURRENTLY PERSCRIBED MEDICATIONS _____

PLEASE EXPLAIN: _____

PHYSICIAN NAME: _____ PHONE: _____

ABOUT YOUR CHILD

CAN YOUR CHILD USE THE RESTROOM IDEPENDENTLY? _____

DOES YOUR CHILD NEED HELP DRESSING/UNDRESSING? _____

PLEASE EXPLAIN ANY CONCERNS/FEARS YOUR CHILD MAY HAVE: _____

_____

ANY DETAILS YOU WISH TO SHARE: _____

_____

PARENT SIGNATURE: _____ DATE: _____