

**BLOOMFIELD JUNIOR ACADEMY MONTESSORI SCHOOL**



**APPLICATION FOR ADMISSIONS:**

**Starting Date:**        m/\_\_\_\_ d/\_\_\_\_        y/\_\_\_\_\_

**End Date**                m/\_\_\_\_ d/\_\_\_\_        y/\_\_\_\_\_

**Casa Program - 18mths. - 6 years**

**Half Day (a.m.)**         **Half Day (p.m.)**         **Full Day**   
 8:30 a.m.-11:45 a.m.        1:30 p.m.-4:30 p.m.        8:30 a.m.-4:30 p.m.

**Extended Hours:**

**Morning:**                **7:00 a.m. - 8:30 a.m.**        **Yes**  **No**

**Evening:**                **4:30 p.m. - 6:00 p.m.**        **Yes**  **No**

**Approximate Drop-Off Time** \_\_\_\_\_        **Pick-Up Time** \_\_\_\_\_

**CHILD'S INFORMATION:**

Child's Last Name			
Child's Given Names (underline name used)			
Date of Birth	Month	Day	Year
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Home Address			
	City	Postal Code	
Home Telephone Number			
Name of Last School Attended			
Languages Spoken at Home			

**FAMILY INFORMATION**

	<b>Mother/Guardian</b>	<b>Father/Guardian</b>
Title (Circle one)	Mrs. Ms. Other:	Mr. Other:
Last Name		
First Name		
Address (if different from child)		
Employer Name and Address		
Work Telephone Number		
Home Telephone Number		
<b>Cell Telephone Number</b>		
Email Address		
Marital Status	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>	
Applicant lives with	Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
Correspondence to be sent to	Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Other _____	
Siblings Name(s)	Age(s)	Gender
1.		
2.		

**MEDICAL INFORMATION**

Name of Child's Physician:	
Physician's Telephone Number:	
Physician's Address:	
Immunization is Attached:	Yes <input type="checkbox"/> No <input type="checkbox"/> Reasons, if no _____
List Child's Allergies:	
Does your child have any special dietary/rest/exercise requirements?	
Does your child have any special physical, cognitive/social or emotional needs?	
<b>History of Communicable Diseases:</b> Has your child had any communicable diseases? (ie. Chicken pox, measles, mumps, etc)	

**EMERGENCY AND CHILD PICK-UP INFORMATION**

<b>NAME OF CONTACT PERSON IN THE EVENT OF AN EMERGENCY:</b>		
Name	Address & Telephone #(s)	Relationship
<b>OTHER PEOPLE ALLOWED TO PICK-UP CHILD FROM THE SCHOOL:</b>		
Name	Telephone	Relationship

In order for your child's application to be processed it is necessary to include the following items:

1. A copy of your child's birth certificate (record of Landing/Passport).
2. A copy of your child's latest report and any other educational assessment reports.
3. A non-refundable registration fee of **\$200.00** payable to Bloomfield Junior Academy Montessori Schools.

**Note:** Thirty days written notice is required in the event of an early withdrawal from the School and at this time, the school will return any post-dated cheques on file.

Please complete this application form and mail or drop it off at the school with all necessary items to:

**Bloomfield Junior Academy Montessori School  
2 Bloomfield Trail  
Richmond Hill, ON L4E 2H8**

Bloomfield Junior Academy Montessori School welcomes children regardless of race, religion, colour or creed.

**Name of Parent or Guardian:** \_\_\_\_\_  
(Please print)

\_\_\_\_\_  
**Date (month/day/year)**

\_\_\_\_\_  
**Parent or Guardian Signature**

**THANK YOU FOR SELECTING BLOOMFIELD JUNIOR ACADEMY MONTESSORI SCHOOLS**

**Office use only:**

Application fee received:      Yes [  ]      No [  ]      Date: \_\_\_\_\_

Deposit received:              Yes [  ]      No [  ]      Date: \_\_\_\_\_

Post-Dated Cheques            Yes [  ]      No [  ]      Date: \_\_\_\_\_

**Date of Withdrawal**

m/ \_\_\_\_ d/ \_\_\_\_ y/ \_\_\_\_\_

\_\_\_\_\_  
**Signature of Administrator**