Dearcroft Montessori Trafalgar Crossing School

297 Oak Walk Drive | Oakville, ON L6H 3R6
Tel: 905-257-3200 info@dearcroftmontessoritc.com Web: www.dearcroft-montessori.com

CASA APPLICATION FORM

Student: _____

Address: _____ **City:** _____

Province: _____ **Postal Code:** _____ **Primary Tel. No.** _____

Birth Date: (day) _____ **(month)** _____ **(year)** _____ **Male** _____ **Female** _____

PROGRAM:

TODDLER
_____ Half Day (am)
_____ Full Day

CASA
_____ Half Day (am)
_____ Half Day (pm)
_____ Full Day

BEFORE/AFTER CARE
_____ Before care
_____ After care
_____ Before & after care

PARENT/GUARDIAN #1

Name: _____

Home Address: _____

Primary Tel: _____

Bus Address: _____

Bus Tel: _____

Cell: _____

Email: _____

PARENT/GUARDIAN #2

Name: _____

Home Address: _____

Primary Tel: _____

Bus Address: _____

Bus Tel: _____

Cell: _____

Email: _____

Emergency Name, Address &Telephone (to call if parents cannot be reached, when child is ill and must be taken home: _____

Siblings (names and birth dates): _____

Transfers (Please provide the name of the School your child has attended, and the length of attendance):

_____

Application for admission into the Montessori program implies your three-year commitment for the duration of each developmental level of the program and your agreement to the terms stated in the tuition schedule.

For Administration use only:
Date of Admission _____ ***Date of Discharge:*** _____

Medical Information:

Student Name: _____

Family Doctor:_____

Address: _____

Tel No: _____

Medical History (please list any health issues/concerns and communicable diseases):

Specialist Services/Therapy (please list any information pertaining to speech therapy, occupational therapy, assessments etc. for your child):

Please list the perons permitted access to your child at school, other than parents and/or guardians on application form. Persons you designate with permission to be released to their care from school:

Please list special dietary restrictions/requirements in respect of diet, rest or physical activity:

Please give written instructions for any medical treatment or drug or medication to be administered during school hours:

_____ _____

Parent /Guardian Signature **Parent/Guardian Signature**

Date: _____ **Date:** _____

Trafalgar Crossing

DEARCROFT MONTESSORI TRAFALGAR CROSSING
INFORMED CONSENT - PROTECTING YOUR PRIVACY

We are committed to protecting your personal information. This is our privacy commitment to you as a parent, student, employee, alumnus or friend of Dearcroft. We collect your personal information only to provide services for which you have registered, to understand your needs and to assist us in creating new services that will serve you better. We do not disclose your personal information to any other organization or individual outside of the School, unless it is necessary to provide you with services from Dearcroft, Dearcroft communications, or when required by law. We provide every registered family with a class email and telephone list. However, if you wish to opt out of such a listing, or if you have any questions or concerns about how your personal information is gathered, used or retained, or wish to opt out of receiving specific Dearcroft communications, please let us know by informing our Administration Office in writing.

Child's Name _____

In consideration of my child's attendance and participation in activities at Dearcroft Montessori, I the undersigned, hereby acknowledge that certain risks are inherent in participation at school and in sports and recreational activities. I agree that Dearcroft Montessori, and its directors, officers, employees, or agents shall not be liable for any injury to my child or loss or damage to my child's personal property arising from, or in any way resulting from, my child's participation at school. I understand that I am responsible for informing Dearcroft Montessori School and its directors, officers, employees, and agents of any medical condition(s) my child has at the time of registration or acquires during their enrollment at the school. In the event of any medical emergency, I hereby give permission selected by Dearcroft and its directors, officers, employees, and agents to secure proper medical treatment for the person(s) named.

Signature of Parent _____ Date _____

Photo Release/Web Site/Social Media Permission

I, hereby, give permission to Dearcroft Montessori to use any photographs posted on Transparent Classroom and any photos/videos of my child sent by direct message, to the school from the parents, as well as any photos of my child for display in the school and/or school fairs and for school brochures and any other promotional material produced by Dearcroft Montessori School. This also includes photos or videos of my child on social media platforms for the school in the form of one of the following channels: Blog, Facebook, Twitter, Instagram, YouTube and Pinterest. At no time will any child's name be published.

Signature of Parent _____ Date _____

Personal Information Release

I, hereby, give permission to Dearcroft Montessori to be included in the class contact list. I understand that this list will contain my child's name and parents' names, telephone number and email addresses. This list will be given to each registered family at the school. I also agree to be included on the school email listing. If I wish to opt out of these list, I will provide Administration with written notice.

Signature of Parent _____ Date _____

Trafalgar Crossing

CASA LUNCH REGISTRATION FORM
2024 – 2025

STUDENT NAME: _____

PARENT NAME: _____

PARENT SIGNATURE: _____

ALLERGIES AND RESTRICTIONS:

1. Please list your child's **food allergies** (enter "none" if no allergies):

_____

_____

2. Do your child's allergies cause an **anaphylactic reaction**?_____Yes _____No

3. Please list your child's **food intolerances** and sensitivities (enter "none" if no restrictions, intolerances, or sensitivities):

_____

_____

4. Please list your child's **food restrictions** (ex. *vegetarian*, *no pork*, etc. Enter "none" if no restrictions):

_____

_____

- The Ministry of Education mandates that all Casa full day students must participate in the offered hot lunch program.
- Catering fee applies for this program
    - $1,750 Casa (20232-2024 pricing)
- Lunch program fees to be confirmed by August 1st
- No refunds for absences

Trafalgar Crossing

PROOF OF AGE

Please provide a copy of your child's birth certificate or passport for proof of age.

Trafalgar Crossing

HEALTH AND IMMUNIZATIONS

Statement of Immunizations for School Entry

The Immunization of School Pupils Act, 1990, requires your child be immunized against six diseases: measles, mumps, rubella (German Measles), diphtheria, tetanus, and polio. This requirement can only be removed if you object to immunization for religious reasons and have completed the necessary exemption form obtained from the Health Department.

School: _____ **Entry Date:**_____

Student Name:_____

Birth Date: _____ _____ _____ **OHIP#**_____
year month day

Address: _____
Street City/Town Postal code

Parent/Guardian: _____ **Phone Number:** _____

Please fill in dates of all immunizations since birth

* Required for school attendance							Recommended vaccines						
Vaccine / Dates Given (yy/mm/dd)	Diphtheria*	Tetanus*	Polio (IPV or OPV)*	Measles*	Mumps*	Rubella*	Hib (haemophilus influenza type B	Pertussis (Whooping Cough)	Pneumococcal (Synflorix™ / Prevnar®)	Meningococcal (NeisVac-C® / Menjugate® or Menactra®)	Hepatitis B	Varicella (chickenpox)	Other

Personal health information on this form is collected pursuant to section 11 the *Immunization School Pupils Act*, R.S.O. 1990, c. I. 1 and will be used by Halton Region's Medical Officer of Health to maintain an immunization record for this child and to take appropriate action to prevent vaccine preventable diseases. Questions about this collection can be directed to nurses within the Immunization Services Program, Halton Region Health Department, 1151 Bronte Road, Oakville, ON, L6M 3L1, 905-825-6000 or toll free at 1-866-442-5866.

Health Information:

Is your child healthy? Yes _____ No _____
If no please describe your child's health concerns:

_____

_____

_____

Does your child have an allergy? Yes _____ No_____
If yes, to what are they allergic?_____

_____

Please describe the type of reaction: _____

_____

Has your child had hepatitis? Yes_____ No_____

If yes, describe the illness: _____

_____

Does your child have a vision problem? Yes_____ No_____

Does your child wear glasses? Yes_____ No_____

Does your child have a hearing problem? Yes_____ No_____

Does your child wear a hearing aid? Yes_____ No_____

Trafalgar Crossing

BEFORE/AFTER SCHOOL PROGRAM
2024-2025

Before Care Program

Time: 7:30 a.m. to 8:45 a.m.
Fee: $150 per month

After Care Program

Dismissal to 6:00 p.m.
$400 per month

Before and After Care Program

Time: 7:30 a.m. to 8:45 a.m. and Dismissal to 6:00 p.m.
Fee: $525 per month

We realize that some parents may require less time in the program than others, however the fees have been standardized to meet the requirements of parents who will utilize these programs on a consistent basis. For this reason, enrollment capacity will be limited. If the need arises for a student who is not registered in the after school program to require after school care (after 3:30 p.m.), a flat daily rate will be charged regardless of time spent in the program. A flat fee daily fee applies for before school drop in.

It is important that emergency/alternative contacts be listed. In the event you may be delayed beyond 6:00 p.m., you must plan for one of your emergency contacts to pick up your child. Late fee of $15.00 applies up to 6:15 pm. and then $1.00 additional per minute thereafter. Enrollment in our after school program will be cancelled if delays past 6:00 p.m. are repeated.

I/We have read the program outline of the Before/After School Program and fully understand the commitment to arrive before 6:00 p.m. each evening. The required payment for this extra programming will be added to our invoice and due monthly or in one payment.

_____ _____
Child's Name Parent's Name

_____ _____
Date Parent's Signature

Trafalgar Crossing

BEFORE/AFTER CARE PROGRAM 2024-2025
REGISTRATION FORM

STUDENT INFORMATION

Student: _____

Address: _____**City:** _____

Province: _____ **Postal Code:** _____ **Home Tel. No.** _____

Birth Date: (day) _____**(month)** _____**(year)** _____ **Male** _____ **Female** _____

PARENT/GUARDIAN INFORMATION

Name: _____ **Name:** _____

Address: _____ **Address:** _____

Home Tel: _____ **Home Tel:** _____

Bus/Cell: _____ **Bus/Cell:**_____

Email: _____ **Email:** _____

Emergency/Alternate Contact Names and Tel Numbers: _____
_____

Before Care Only _____
(7:30 a.m. – 8:45 a.m.) $150/month

After Care Only _____
(Dismissal - 6:00 p.m.) $400/month

Before and After Care _____
(7:30a.m./ Dismissal – 6:00 p.m.) $525/mth

Monthly fees are to be paid in advance by post-dated cheques dated the first of each month or by e-transfer. Fees for before and after care will be added to individual invoices.

_____ _____
Parent Signature **Parent Signature**

Date: _____ **Date:** _____

Parent Handbook
RECEIPT & WAIVER FORM

Dear Parents/Guardians,

Please thoroughly review the Parent Handbook which contains the policies and procedures for Dearcroft Montessori's return to school. This form must be signed and returned to school prior to your child's attendance in September. This form will be kept in your child's file for the duration of the school year.

Thank you in advance for your cooperation.

Kindly,

Dearcroft Montessori Trafalgar Crossing

I, _____ (print your name) the parent/guardian of

_____ (print child's name), hereby acknowledge receipt of Dearcroft Montessori School's Parent Handbook I have read and agree to adhere to all the policies and regulations set forth in this handbook. I acknowledge and understand that the services, sanitary practices, screening processes provided by Dearcroft during are as safe as possible for my child(ren). I waive any liability of Dearcroft because of contracting a communicable disease.

I agree to respect and adhere to the protocols and advice from government health officials to help minimize the risk for all Dearcroft families and staff.

Parent/Guardian Signature: _____

Date: _____

CASA SECOND/THIRD YEAR
CLASS TRIP PERMISSION

I do hereby give permission for my child,

(Child's Name) _____

to participate in the occasional class trip or outing, as planned by Dearcroft Montessori Trafalgar Crossing during the school year. I also give permission for my child to participate in the occasional school walk with Dearcroft Montessori, off school property, as required during the year.

Supervision will be by teachers, or teachers assisted by volunteer parents.

I fully understand that the risk factor will be higher than if my child were at his/her regular work at school. Realizing this, I allow my child to participate, and absolve Dearcroft Montessori Trafalgar Crossing and its directors, officers, employees and agents, or any person acting on behalf of the school, from legal responsibility.

Parent/Guardian Signature: _____

Date: _____

Trafalgar Crossing

NON-MEDICATED ITEMS PERMISSION FORM

Student Name: _____

I hereby give Dearcroft Montessori Trafalgar Crossing permission to administer the following non-medicated preparations listed below in accordance with the directions for use listed on the container.

Please check item, frequency, and duration of use.

Non-prescription medication	Mark all that apply	Duration of use (e.g., daily, seasonal, as needed)
Baby Wipes		
Diaper Ointment		
Baby Powder		
Sunscreen		
Insect Repellent		
Creams/Lotions		
Hand Sanitizer		
Lip Balm		
Other:		

All non-medicated preparations must be provided to Dearcroft Montessori in the original container and will be administered from original container. All non-medicated preparations will be always stored out of reach of students and will only be administered by a Dearcroft staff member.

I release Dearcroft Montessori Trafalgar Crossing from any liability from administering these products.

Parent Signature: Date:

_____ _____