



Child's First Name: _____ Last
Name: _____

Date of Birth: ____/____/____ Teacher: _____ Grade: _ Room
#: _____

Parents or Guardian's Name(s):

Address: _____ Home Phone #: _____

Mother's Work Phone # _____ Father's Work Phone#: _____

Mother's Cell# _____ Father's Cell
Phone#: _____

Person(s) authorized to pick up your child / Emergency Contacts: (Person must show picture I.D.)

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

Name: _____ Relationship: _____
Phone#: _____

Student lives with: ____ Father ____ Mother ____ Step Parents ____ Foster ____ Legal Guardian ____
Other **Primary Language:** ☐ English ☐ Spanish ☐ Other: _____

Is your child under medical care or taking any medication(s)? ☐ Yes ☐ No

If yes, please check all of the following conditions that your child has and indicate if medication needs to be dispensed at school?

☐ Bee Sting Allergy Epi-pen ☐ Yes ☐ No ☐ Other Allergies: _____

☐ Asthma Inhaler ☐ Yes ☐ No ☐ Special Needs /

Disability: _____



☐ Diabetes Insulin ☐ Yes ☐ No ☐

Other: _____

☐ Vision / Hearing Glasses ☐ Yes ☐ No

Family Health Care: Physician's Name: _____ Phone
#: _____

Address: _____ Medi-Cal: ☐ Yes ☐ No

Health Insurance# _____

Does the Little Thinkers Montessori program have permission to use photos of your child in educational or promotional materials? (There is no cost.) Yes: _____ No: _____

Does your child have permission to check out at 6:00 pm and walk home? Yes: _____ No: _____

Parent or Guardian Signature: _____ **Date:** _____

For Office Use Only

Enroll Date: _____ Initials: _____

Date Disenrolled: _____ Reason: _____