WHITE ROCK MONTESSORI
2023/2024

Morning Class (8:55am - 1:00pm)
$287.00 (5 days a week)

Full Day Class (8:55 am - 3:15 pm)
$333.00 (5 days a week)

TO HOLD YOUR PLACE, WE REQUIRE THE FOLLOWING:

1) REGISTRATION FEE: $100.00 non refundable registration fee.
2) LAST MONTHS FEES: One month tuition fees applied to your June 1 payment.
3) SUPPLY FEE $30 per child for the school year.
4) E-TRANSFER: E-Transfer your monthly fees on the first of each month to:
cobblehillmontessori@gmail.com (September 1 to May 1)

***PROGRAM YOUR CHILD WILL ATTEND:** ____

I understand the payment policies and due dates on this fee form. I also understand the policies outlined in the Parent Handbook.

PRINTED: ____
Parent/Guardian Name

SIGNED: ____ **DATE:** _________________________

* In case of withdrawal from school, parents are required to give 1 full calendar month written notice of the withdrawal from the program.

* Please note absence due to illness or holidays are not exempt from payment.

* White Rock Montessori conforms to the public school holidays.

* These fees are discounted as all families are eligible for Ministry Funded Child Care Fee Reduction Initiative Discount.

WHITE ROCK MONTESSORI

14560 North Bluff Rd
White Rock, BC. V4B OB1
Tel: 604-355-4654
Email: info@whiterockmontessori.ca

Name of Child: ____

Birth date: ______________________ Gender: ____________________

Starting Date: ____

Mother's Name: ____

Cell: ______________________ Work Ph: ____________________

Email: ____

Father's Name: ____

Cell: ______________________ Work Ph: ____________________

Email: ____

Complete Address: ____

Name and ages of brothers and sisters: ______________________________

____

Has your child had previous group experiences?

____

____

Does your child have any special problems such as medical, allergies, or behavioural issues, which we should know about?

____

____

Do we have your permission to use your child's photos on our website, Facebook or other marketing materials? Yes, I give my permission ____________ No, I am not comfortable allowing this ____________

SCHOOL REGISTRATION FORM IMMUNIZATION RECORD

Attach a photocopy of immunization record, or indicate dates that immunizations were received.

Diphtheria, Tetanus and Pertussis (DPT): ______________________________

Polio: ____

Meningitis (Hob D): ____

Measles, Mumps and Rubella (MMR): ______________________________

EMERGENCY HEALTH INFORMATION

Doctor's Name: ______________________________________ Phone: _________________________________

Address: ____ Care Card Number: _____________________

Special Diet (If any): ____

____

CONSENT FOR EMERGENCY CARE I authorize the staff at White Rock Montessori to call a medical practitioner or ambulance in the case of accident or illness of my child(ren), if the parent can not immediately be reached.

Print: ____

Signed: ________________________________ (Parent or legal guardian) Date: __________________________

FIELD TRIP CONSENT I hereby give White Rock Montessori permission to take my child for walks away from the building that in its discretion are appropriate or necessary. I hereby give Mann Park Montessori permission to take my child on field trips that in its discretion are deemed appropriate or necessary.

Signed: ____ Date: _____________________________

ALTERNATIVE PERSON TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY:

Name: ____ Relationship: _________________________________

Phone: ____

ALTERNATIVE PERSON(S) AUTHORIZED TO PICK UP CHILD

Name: ____ Relationship: _________________________________

Ph: ____

Name: ____ Relationship: _________________________________

Ph: ____

PERSON NOT PERMITTED TO PICK UP CHILD

Name: ____ Relationship: _________________________________

Ph: ____

PARENT OR GUARDIAN PROVIDING INFORMATION

Print name: ____

Signed: ___________________________________ (Parent or legal guardian) Date: _______________________

EMERGENCY CONSENT FORM **WHITE ROCK MONTESSORI**

Child's name: ______________________________ Birth date: ____________________________

Address: ____

Child lives with: ____

Parent's Name: ____

Cell: ______________________________________ Work Phone: __________________________

Parent's Name: ____

Cell: ______________________________________ Work Phone: __________________________

Emergency Contact: _________________________________ Ph: __________________________

Child's Doctor: _____________________________________ Ph: __________________________

1. Allergies: ____

2. Medications: ____

Care Card #: ___________________________________ Date Effective: _____________________

CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency or medical centre when I cannot be contacted.
2. I give consent for my child to receive medical treatment.

Signature of Parent/Guardian ________________________________ Date _________________

PICTURE OF CHILD HERE