

HAZEL CREEK MONTESSORI

Student Admissions List

Student's Name _____
Parent's Name _____ cell _____ hm ph: _____
Email _____
Address _____
Date Information Sent _____ Date Observed _____
Student's Start Date _____ Class _____

- Given information packet about the school and program
- Tour of the school's and grounds
- Given information about Montessori and school curriculum
- Observed classroom
- Met teachers
- Shown message center
- Shown sign-in sheet
- Show where to put lunches
- Shown child's cubby
- Shown where to put tuition checks-payment policy
- Given current newsletter
- Shown medication forms
- Given schedule for the room, start times, circle, lunch, etc.
- Given information about extended day program
- Given information about lunch program
- Admissions for turned in and signed
- Student in computer
- Registration fee received
- One month deposit received (non-refundable)
- Start date confirmed
- Immunization form complete
- Phone messages and emergency information explained
- Read disaster plan
- Student forms files in office

Parent Signature _____ Date _____

PARENT PAYMENT CONTRACT

Tuition will be charged through our ACH debit on the first of each month. Upon registration, a \$75 non-refundable registration fee plus a one month deposit and an annual supplies fee is due. Your deposit is non-refundable. At the point at which your contract ends, your deposit will be used for the last 30 days of your child's attendance.

I, _____, understand that I am liable for the monthly tuition when it is due. My child will attend for either a 10 month (September-July) or 12 month (September-September) school calendar year. If we enroll our child mid-year, we will be financially responsible for the balance of that school calendar year.

HALF DAY PROGRAM

_____ (parent initials) I am signing my child up for 10 or 12 (circle one) month program. I understand that the half day program follows the public school calendar for school closure, and that my child will not attend HCM during these closures. Some months are longer and some are shorter, however tuition is divided into equal monthly payments for 10 or 12 months.

FULL DAY PROGRAM

_____ (parent initials) I am signing my child up for 10 or 12 (circle one) month program. Some months are longer and some are shorter, however tuition is divided into equal monthly payments for 10 or 12 months.

I understand that I am liable for one annual payment or monthly payments divided equally over a 10 or 12 month period. Should I decide to withdraw my child from the program, or change their original schedule, I am still liable for the balance of the 10 or 12 month contract.

Parent Signature _____ Date _____

*Hazel Creek Montessori does not prorate or make up days due to weather, sickness, vacations, etc. Extra time and days need to be pre-approved by the office.

Hazel Creek Montessori

Admission Information

Student Information

Student's Name _____			
<i>Last/Middle/First</i>			
Address _____			
<i>Street/City/State/zip</i>			
Age	Date of Birth	Sex	Nickname
Mother's Name		Address	Phone Number & Email
Business		Address	Phone Number
Father's Name		Address	Phone Number & Email
Business		Address	Phone Number

Physician			Address	Phone Number
Dentist			Address	Phone Number
Date of Last Physician's Exam ___/___/___				
In case of an emergency, contact student's: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other				
IN CASE OF AN EMERGENCY, WHO TO CALL OTHER THAN PARENT/GUARDIAN:				
Name _____		Relationship _____		
Address			Phone Number	
Allergies		Medical Problems		
Special issues that could affect the student's classroom abilities				

Program Entering _____	Admission - Date Requested ___/___/___
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DAILY SCHEDULE - SUMMER AND/OR FALL 2017

Child		Age		DOB	
Persons allowed to pick up your child					
TODDLER (1yr - 2.5 yrs)		___ 3 Full Days	___ 3 Extended Days		
Full Days - 9 Hrs or less		___ 4 Full Days	___ 4 Extended Days		
Extended Days - 9 Hrs or more		___ 5 Full Days	___ 5 Extended Days		
NAPPERS (2.5 - 4 yrs)	___ 3 Half Days	___ 3 Full Days	___ 3 Extended Days		
Half Days - 9-Noon	___ 4 Half Days	___ 4 Full Days	___ 4 Extended Days		
Full Days - 9 Hrs or less	___ 5 Half Days	___ 5 full Days	___ 5 Extended Days		
Extended Days - 9 Hrs or more					
PRESCHOOL (4 - 5 yrs)	___ 3 Half Days	___ 3 Full Days	___ 3 Extended Days		
Half Days - 9-Noon	___ 4 Half Days	___ 4 Full Days	___ 4 Extended Days		
Full Days - 9 Hrs or less	___ 5 Half Days	___ 5 full Days	___ 5 Extended Days		
Extended Days - 9 Hrs or more					
BIG KIDS (6 - 12 yrs)					
After-School Care	_____ Hours	_____			
Non-Contract Days	_____ Hours	_____			
Please circle the days your child will attend	Mon	Tues	Wed	Thurs	Fri
Daily Drop off Time	_____	Daily Pick Up Time	_____		

Family Background
CONFIDENTIAL

Child's Name _____ Nickname _____				
Interest _____				
Habits _____				
Siblings/Age _____				
Parent Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Other
Primary Care Provided by	<input type="checkbox"/> Both	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other
Previous Child Care _____				
Reason for Leaving _____				
Reason for Applying to Hazel Creek _____				
Referred by _____		Intended Length of Stay _____		
Naps _____	Schedule _____	Habits _____		

<u>HEALTH</u>
Childhood Diseases _____
<u>DIET</u>
Allergies _____
Special Requirements _____

Goals you wish for your child to achieve _____
Comments _____

HAZEL CREEK MONTESSORI
RELEASE FORM

The undersigned have enrolled _____
To attend Hazel Creek Montessori School activities and participate in the programs and activities offered. In consideration, the undersigned releases and discharges Hazel Creek Montessori, it's officers and employees from liability of any kind to the child or the undersigned for any loss or injury to the child while participating in school or extended day program activities. The undersigned agrees that this release is intended to be as broad as permitted under the law of the State of Washington and if any part of the application is found unenforceable the remainder shall be enforced in full.

Parent or Guardian Signature _____ Date ___/___/___

Parent or Guardian Signature _____ Date ___/___/___

Director _____ Date ___/___/___

HAZEL CREEK MONTESSORI

Aquatic Center

I (we) hereby release, waive, consent not to sue and discharge Janice Pedersen, assisting staff, their spouses, heirs and next of kin for any loss, personal damage or bodily injury to my (our) child while participating in the aquatic program and at Hazel Creek Montessori School.

I (we) give my (our) child _____ permission to participate in the swimming program at Hazel Creek Montessori Aquatic Center. In consideration, the undersigned releases and discharges Hazel Creek Montessori, its officers and employees from liability of any kind to the children of the undersigned for any loss or injury to the child while participating in the swimming program. The undersigned agrees that this release is intended to be as broad as permitted un the law of the State of Washington and if any part of the application is found unenforceable to the remainder may be enforced in full

Print Name of Participant

Print Name of Parent or Guardian _____
Parent or Guardian Signature _____ Date ___/___/___
Phone Number () ____ - ____

Print Name of Parent or Guardian _____
Parent or Guardian Signature _____ Date ___/___/___
Phone Number () ____ - ____

Emergency Information

Child's Name _____		Date enrolled ___ / ___ / ___		DOB ___ / ___ / ___	
Address _____					
E-mail _____					
Mother's Name _____		Work Location _____			
Home # () _____ - _____		Work # () _____ - _____		Cell # () _____ - _____	
Father's Name _____		Work Location _____			
Home # () _____ - _____		Work # () _____ - _____		Cell # () _____ - _____	
Allergies: _____					
Person to be notified in case of an emergency and appropriate phone numbers: _____					
Doctor's Name _____		Phone # () _____ - _____			
Dentist Name _____		Phone # () _____ - _____			
Insurance Carrier _____		Plan # _____			
Hospital of Choice _____		Phone # () _____ - _____			
List of people who may pick up your child _____					

Medical Release

In case of an emergency, I understand the center will try to contact me first. If there is not time, the school will call 911 (who then send an emergency vehicle, medic, etc.). Unless otherwise requested, the center will transport to the Virginia Mason Clinic. I hereby give my consent for my child's doctor (or the center's consulting physician, if the child's doctor isn't available) to conduct and x-rays, give blood test, or give any and all treatment that may be deemed necessary in the event of an emergency.

Parent or Guardian Signature _____ Date ___ / ___ / ___

Parent or Guardian Signature _____ Date ___ / ___ / ___

Permission Release

I grant permission for my child to use all program equipment, participate fully in all activities, for my child to leave the premises under supervision for hikes and field trips, for my child to be included in evaluations and also to be used in photos and videos for publicity.

Parent or Guardian Signature _____ Date ___ / ___ / ___

Parent or Guardian Signature _____ Date ___ / ___ / ___

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

Company Name Hazel Creek Montessori, Inc. Company ID Number 91-1500566

I (we) hereby authorize Hazel Creek Montessori, Inc., hereinafter called COMPANY, to initiate debit entries to my (our) Checking Account/ Savings Account (select one) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Name _____	Branch _____
City _____	State _____
Zip _____	
Routing Number _____	Account Number _____
Dollar Amount \$ <u>Monthly Tuition</u> _____	Starting Transaction Date _____
Parent's Names _____	
Child's Name _____	Class _____
Weekly Schedule _____	
Deposit Paid \$ _____	Regular Tuition \$ _____
This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. All notifications of termination must be made prior to the 1 st of the month for a 30 day notice per PARENT PAYMENT CONTRACT.	
Name(s) _____	ID number <u>N/A</u> _____
Date _____	Signature _____
NOTE: SIGNATURE MUST BE AN AUTHORIZED SIGNER ON THE ABOVE ACCOUNT. NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS <u>MUST</u> PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.	



Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:

Reviewed by: _____ Date: _____

Signed Cert. of Exemption on file? Yes No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YY):	Sex:
_____	_____	_____	_____	_____

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

◆ Required for School and Child Care/Preschool

● Required Only for Child Care/Preschool

Date
Date
Date
Date
Date
Date

MM/DD/YY
MM/DD/YY
MM/DD/YY
MM/DD/YY
MM/DD/YY
MM/DD/YY

Required Vaccines for School or Child Care Entry

◆ DTaP, DT (Diphtheria, Tetanus, Pertussis)						
◆ Tdap (Tetanus, Diphtheria, Pertussis)						
◆ Td (Tetanus, Diphtheria)						
◆ Hepatitis B <input type="checkbox"/> 2-dose schedule used between ages 11-15						
● Hib (<i>Haemophilus influenzae</i> type b)						
◆ IPV / OPV (Polio)						
◆ MMR (Measles, Mumps, Rubella)						
● PCV / PPSV (Pneumococcal)						
◆ Varicella (Chickenpox) <input type="checkbox"/> History of disease verified by IIS						

Recommended Vaccines (Not Required for School or Child Care Entry)

Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV, MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

- a verified history of Varicella (Chickenpox).
- laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

- | | | |
|--------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rubella | _____ |
| <input type="checkbox"/> Hib | <input type="checkbox"/> Tetanus | |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Varicella | |

Licensed healthcare provider signature _____ Date _____
 (MD, DO, ND, PA, ARNP)

Printed Name _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at <https://wa.myir.net>. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements.**

- If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS.**

Reference guide for vaccine abbreviations in alphabetical order

For updated list, visit <https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf>

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order

For updated list, visit <https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf>

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		