**SESSION INFORMATION**

**In which term would you wish to commence?** Term \_\_\_ of 20\_\_\_

**Session Dates:** Thursdays : 8 February, 22 February, 8 March, 15 March ?? (school tour)

 OR Fridays : 9 February, 23 February, 9 March, 16 March.

**Session Times:**  9am – 11:00am

**CHILD INFORMATION**

|  |  |
| --- | --- |
| **Child’s First Name:** | **Child’s Surname:** |
| **Child’s Preferred Name:** | **Sex M/F:** |
| **Date of Birth:** | **Current Age:** |
| **Country of Birth:** | **Citizenship:** |
| **Current Postal Address:** |  |
|  |  |
| **Post Code:** | **Telephone:** |

**Child Care Information**

**Current Child Care/Playgroup:**

Child Care/Playgroup Name:

Suburb/State:

Number of Days Attendance per Week:

Name of Director/Head Educator:

Attended From: Attended To:

**Previous Child Care/Playgroup:**

Child Care/Playgroup Name:

Suburb/State:

Number of Days Attendance per Week:

Name of Director/Head Educator:

Attended From: Attended To:

**APPLICATION FORM (cont’d)**

**Prenatal Information**

Please briefly describe your pregnancy, labour, childbirth. Please describe any concerns:

**Medical Information**

Has your child been immunised? Yes  No 

Does your child have a known disability? Yes  No 

Does your child have a known health issue? Yes  No 

Does your child have a medical condition of which the school should be aware? Yes  No 

If Yes to above questions, please provide details below. If No, proceed to next section.

Please tick 

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Intellectual  | Social/Emotional  | Hearing |  |  |
| Physical  | Vision  | Speech |  |  |
| Allergy\*  | Anaphylaxis  | Language |  |  |
| Glue Ear  | Diabetes Mellitus Type 1  | Asthma |  |  |
| Autism/Aspergers  | Febrile Convulsions  | Epilepsy |  |  |

 Other (please specify)

 \*Allergy (please specify)

Please provide a brief description of condition and treatment

**Specialist Information**

Please describe any developmental concerns you may have about your child:

Has your child undergone any recent developmental progress support or assessment? Yes  No 

Has your child had any recent allied health or medical specialist assessments? Yes  No 

If Yes to either question, please provide details below. If No, proceed to next section.

Please tick 

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Paediatrician  | Speech Pathologist  | Psychologist |  |  |
| Orthopaedic  | Behavioural Psychologist  | Other |  |  |
| Physiotherapist  | Occupational Therapist  |  |  |  |

 Other (please specify)

 Please provide a brief description of condition and treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION FORM (cont’d)**

**FAMILY INFORMATION**

|  |  |
| --- | --- |
| **Parent/Guardian/Carer 1**  | **Parent/Guardian/Carer 2** |
| **Title:**  | **Title:**  |
| **First Name:** | **First Name:** |
| **Surname:** | **Surname:** |
| **Relationship to Applicant:** | **Relationship to Applicant:** |
| **Mobile:** | **Mobile:** |
| **Home Phone:** | **Home Phone:** |
| **Work Phone:** | **Work Phone:** |
| **Email:** | **Email:** |
| **Current Address:** | **Current Address:** |
|  |  |
| **Postcode:** | **Postcode:** |
| **Postal Address (if different):** | **Postal Address (if different):** |
|  |  |
| **Postcode:** | **Postcode:** |
| **Occupation:** | **Occupation:** |
| **Company/Organisation:** | **Company/Organisation:** |

Please tick  any that apply:

Parents Married and Living Together  Single Parent  Parents Separated  Parents Divorced 

Mother Deceased  Father Deceased  Mother is remarried  Father is remarried 

Name (s) of Step parents if applicable:

Child lives with: Mother  Father  Both 

Other (please specify):

**Siblings**

Name(s): Age: DOB: Sex: M/F

Name(s): Age: DOB: Sex: M/F

Name(s): Age: DOB: Sex: M/F

**PROGRAM/VENUE INFORMATION**

The Parent Toddler Program is for children aged 15mths – 3yrs, attending a 2 hour session, one day a week with a parent/carer. Sessions are led and facilitated by a Montessori Infant Guide.

Venue – Montessori International College. 880 Maroochydore Road, Forest Glen. Our school location is on STARK LANE, Forest Glen. Please place Stark Lane into your GPS, entrance to our school is via the roundabout on Stark Lane. On arrival, please use the entrance of the two-storey brick building.

**APPLICATION FORM (cont’d)**

**FEE INFORMATION**

The 2018 fee for the Parent Toddler Program is: Per Child, per term $200.

 Per Child, per session $50

Please see payment options outlined below. Payment to be made for term by Tuesday 6th February 2018.

\*Please note that payment is non-refundable and cannot be transferred or applied as credit. Payment is required to confirm your child’s place. Numbers are limited.

I/We herby attest that the information contained in this application is true and accurate to the best of my/our knowledge. I/We acknowledge that attendance to MIC’s Parent Toddler Program is separate to enrolment in the Montessori International College. I/We understand that to enrol my child at MIC I need to follow the Application Process as outlined in the MIC Enrolment Information Handbook. I/We understand that all policies pertaining to MIC also apply to the Parent Toddler Program.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Carer 1 Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Carer 2 Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This form is to be completed and forwarded to:**

 Enrolments Coordinator

 Montessori International College

 PO Box 7309

 SIPPY DOWNS QLD 4556 Australia

 Telephone: +61 7 5442 3807

 Email: enrolments@montessori.qld.edu.au

**Payments can be made via:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chosen.jpg**Expiry Date: / CCV:** | **Credit card**To pay via MasterCard or VISA.1% fee charged for Credit Card Payments. Please provide your credit card number below.    |  | envelope.jpg | **Mail**Mail your cheque to: **Montessori International College**P.O Box 7309Sippy Downs Qld 4556 |
| **Electronic Funds Transfer****Bank Name:** Westpac Bank**Account Name:** Montessori International College**BSB:** 034 198**Account No.** 530490**Reference:** Family Name, First Name |  | C:\Users\cassandra\Desktop\eftpos-2.jpg880 MAROOCHYDORE ROAD FOREST GLEN P.O. BOX 7309 SIPPY DOWNS QUEENSLAND 4556 AUSTRALIAPH: + 61 7 5442 3807 EMAIL: admin@montessori.qld.edu.au WEB: [www.montessori.qld.edu.au](http://www.montessori.qld.edu.au)ABN: 83 128 791 828 | **Eftpos or Cash**pay by person at: 880 Maroochydore Road (Stark Lane), Forest Glen |
| **Direct Debit**Please contact the office to arrange a direct debit. |

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