Spondeo Montessori Preschool & Kindergarten
2680 S. Val Vista Dr. Gilbert, AZ 85295 480-374-3911 spondeopreschool.com

New Student Enrollment

Child Information:

_____

Child's Last Name Child's First Name Child's Middle Name

Child's Gender: M F Child's Date of Birth:_____/_____/_____

Parent/Legal Guardian #1

_____
Legal Name (Frist, Middle, Last)

_____
Relationship to Student

_____
Home Address

_____
City, State, Zip

_____
Home Phone

_____
Cell Phone

_____
Work Phone

_____
Email Address

_____
Employer

_____
Occupation

Parent/Legal Guardian #2

_____
Legal Name (Frist, Middle, Last)

_____
Relationship to Student

_____
Home Address

_____
City, State, Zip

_____
Home Phone

_____
Cell Phone

_____
Work Phone

_____
Email Address

_____
Employer

_____
Occupation

School/Child Care Information:

Is your child currently or previously been enrolled in preschool/childcare? Y / N

If yes, name of current or former preschool/childcare provider?_____

Did the staff express any concerns regarding your child? Y / N

If so, what were they?_____

Has your child ever been asked to leave a school/childcare? Y / N

If so, why?_____

Please describe, if any, difficulties that your child may have had or has in another school or group setting:

_____

_____

Special Needs Information:

In order to best serve your child, it is imperative that you complete this section accurately.

Has your child ever received special services for any of the following:

_____Speech/Language _____Developmental Delays _____Behavioral Support

Is your child currently receiving special services for any of the following:
_____Speech/Language _____Developmental Delays _____Behavioral Support

If yes to either questions, please explain:_____
_____

_____

_____

Diet:

Does your child consume cow's milk? Y / N
Does your child have special dietary restrictions? Y / N If yes, please list:_____
_____

Does your child have any food allergies? Y / N If yes, which foods?_____

_____

Health Information:

Does your child have routine medical care? Y /N
Does your child have a medical condition that requires immediate access to medication or a specific response from staff? Y / N If yes, please explain:_____

Does your child take medication on a routine basis? Y / N During school hours? Y / N

_____
Name of Medication Purpose

_____

Name of Medication Purpose

Please list any other allergies:_____

Epi Pen needed?* Y / N Benadryl needed?* Y / N

**Please bring these items to the office for storage for your child's use. If Epi Pen is needed, 2 pens must be provided at all times.*

Does your child have any vision or hearing problems? Y / N If yes, please explain:_____

_____

Medical Contacts:

Physician to be called in an emergency:

_____

Name Address Phone Number

Dentist to be called in an emergency:

_____

Name Address Phone Number

Preferred Hospital:

_____

Name Address Phone Number

Developmental:

Was your child's birth full term? Y / N If premature, gestational age:_____

Age child walked:_____ Age child talked:_____

Is your child potty trained? Y / N If yes, age at toilet training:_____

Word used for bowel movement:_____

Word used for urination:_____

Family and Childcare Information:

Please list the name and ages of all children residing in the home with the child:

_____

First, Middle, Last Name Gender Birth Date School Name (If attending)

_____

First, Middle, Last Name Gender Birth Date School Name (If attending)

_____

First, Middle, Last Name Gender Birth Date School Name (If attending)

Parents' marital status:_____

With whom does your child live?_____

Primary language spoke at home:_____ Secondary language:_____

Social:

What does your child enjoy doing most?_____
What activities does your family enjoy doing together?_____
Does your child prefer to play alone or with playmates?_____
When playing with playmates, how does your child react to conflict (words, crying, hitting, etc)?_____
_____
_____
Religious or ethnic beliefs to take into consideration?_____
_____
Your child's favorite color?_____
Your child's favorite toys/games?_____
Please list any pets your have at home (name and type):_____
Food likes and dislikes?_____

Routines:

The following information would help us have an idea of your child's typical day:

Are meals at a set time? Y / N Where are meals eaten?_____
Are meals eaten with adults? Y / N Does your child sit in a high chair/booster chair? Y / N
What time does your child go to bed?_____ What time does your child wake up?_____
Does your child sleep through the night? Y / N
Is your child prone to nightmares? Y / N
Does your child have his/her own room? Y / N Does your child sleep alone? Y / N
Does your child still nap? Y / N For how long?_____
Does your child need assistance falling asleep? Y / N

In what ways do you encourage independence in your child?_____
_____
On average, how many hours of TV/tablet/iPad times does your child watch per day?_____

Are you aware that Montessori is based on a 3 year cycle? Y / N
What brought you to Spondeo Montessori?_____
_____
What are your goals for you child this year?_____
_____