Spondeo Montessori Preschool & Kindergarten

135 S. Val Vista Dr. Gilbert, AZ 85296 - 480-374-3911 - spondeopreschool.com

New Student Application

Child Information:

____ Child's Date of Birth:______/______/_______

Child's Last Name, First Name, Middle Name Child's Gender: M/ F

Parent/Legal Guardian #1

____
Legal Name (First and 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 (First and Last)

____
Relationship to Student

____
Home Address

____
City, State, Zip

____
Home Phone

____
Cell Phone

____
Work Phone

____
Email Address

____
Employer

____
Occupation

School/Child Care Information:

Has your child previously been in preschool/childcare? **Y / N**

If yes, name of former preschool/childcare provider:____

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

If so, why?____

Please describe any challenges 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 been assessed in any of the following developmental areas:

_____Speech/Language _____Developmental Milestones/Progress or Delays _____Behavioral Support

If so, did they receive an official diagnosis: **Y / N**

Please select the area(s) and provide information on the diagnosis below:

_____Speech/Language _____Developmental Milestones/Progress or Delays _____Behavioral Support

____

____

Diet:

Does your child consume cow's milk? **Y / N**

Does your child have special dietary restrictions? **Y / N** If yes, please list:_____________________________

____D

oes your child have any food allergies? **Y / N**

If yes, please list any allergies:

____

Is an EpiPen needed?* **Y / N** Is Benadryl needed?* **Y / N**

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

Health Information:

Does your child take medication on a routine basis? **Y/N** Is the medication needed during school hours **Y/N**

If yes, please explain in detail: ____

____

Name of Medication/ Purpose

____

Name of Medication/ Purpose

____

A medication consent form must be completed and a doctor's note with specific instructions attached and kept on file.

Does your child have any vision or hearing problems? **Y / N**

If yes, please explain:

____

Medical Provider Information:

Child's Physician:

____*N*

ame and Phone Number

Preferred Hospital:

____*N*

ame- Address -Phone Number

Developmental:

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

Does your child nap? **Y / N** If so, how long is the nap? ____________________________

The age your child started walking:___________________ The age your child started talking: _____________

Is your child toilet independent? **Y / N** If yes, their age at toilet training:_____________

Family and Childcare Information:

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

____

Parents' marital status:____

With whom does your child live?____