

**SKOKIE MONTESSORI SCHOOL**

**8401 North Karlov Avenue  
Skokie, Illinois 60076  
(847) 679-4614**

Start Date: \_\_\_\_\_

Discharge Date: \_\_\_\_\_

**SUMMER PROGRAM  
2018 Application  
3-6 Year Old (Half and Full Day)**

Please complete this form fully in ink and return it with the appropriate fee. Make checks payable to "Skokie Montessori School". The following information is submitted as part of this application for my child.

\_\_\_\_\_ **New Student**

\_\_\_\_\_ **Returning Student**

Child's Full Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Place of Birth \_\_\_\_\_

Names & Ages of Sibling \_\_\_\_\_

Family's Email Address: \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Cell Phone/ Pager \_\_\_\_\_

Name of Firm \_\_\_\_\_ Work Hours/ Days \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ Cell Phone/ Pager \_\_\_\_\_

Name of Firm \_\_\_\_\_ Work Hours/ Days \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Marital Status of Parents \_\_\_\_\_ Custodian Parent(s) \_\_\_\_\_

List any other members of the household and their relationship to the child \_\_\_\_\_

in case of emergency, may we contact your physician and if necessary, take your child to the nearest hospital at your expense? \_\_\_\_\_

Child's Physician \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_

Is your child under special medical care? \_\_\_\_\_

If so, may we consult your physician? \_\_\_\_\_

If your child has an allergy, special physician or emotional condition, what is the nature of it? \_\_\_\_\_

Has your child received the immunization and vaccination required by the Health Dept.? \_\_\_\_\_

**LIST 2 LOCAL PEOPLE WE MAY CALL IN CASE OF AN EMERGENCY IF WE CAN'T REACH PARENTS:**  
These names will be considered an automatic to your transportation authorization form.

Name 1. \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Name 2. \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

