



Enrollment Checklist

Child's Name _____

To complete the enrollment process for your child, please return the following forms:

1. Enrollment Form
2. Student Information
3. Authorization to Administer Medication
4. Emergency Information & Authorization for Treatment and Transportation
5. Home Language Survey
6. Preventative Medication Authorization Form
7. Breakable Materials Form
8. Request for Records
9. Preschool Financial Policy
10. Tuition and Fees

The following information is also required to accompany the Enrollment Checklist forms and complete the enrollment process:

1. Copy of most recent Individualized Education Plan/504 Plan (if needed)
2. Free and Reduced Lunch Form
3. General Health Appraisal Form (Due 30 days prior to the start of school)
4. Copy of Immunizations or Exemption Form
5. Copy of Birth Certificate
6. Proof of Mesa County Residency

Monument View Montessori Charter School admits students of any sex, race, color, creed, religion, national, or ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. MVMCS does not discriminate on the basis of sex, race, color, creed, religion, national, or ethnic origin in the administration of its educational policies, admissions policies or financial aid program.



Parent/Guardian Name

Parent/Guardian Address

Occupation

Employer

Cell Phone

Email Address

Parents/Guardians are:

- Married Separated Divorced Single Parent Domestic Partners

With whom is the child living? _____

Who is the legal guardian? _____

Special Contact Instructions while student is in care of MVMCS: _____

Please list the names and relationship of all parents and/or significant adult family members living with child:

SIBLINGS

Name

Date of Birth

School/Grade



Student Information

Primary Language _____ Other Language(s) Spoken _____

Please list your child's strengths, interests, and talents.

Please list any organized groups or special classes in which your child participates.

Why are you interested in having your child attend Monument View Montessori Charter School?

Please share any additional information you would like us to know about your child or your family, including any areas needing special attention, as well as your goals for your child at our school.



Are there any assessments, reports, or documentation regarding this child that we should know about?

Yes No

If yes, please explain: _____

Previous school(s) attended, with dates of attendance.

Has your child ever experienced discipline challenges (including suspension or expulsion) in an educational setting? Yes No

If yes, please explain: _____

Have any family members attended a Montessori school? Please list who, where, and when.

Does your child/family know anyone at Monument View Montessori Charter School?



Authorization to Administer Medication

Child's Name _____

Name of Medication: _____ Dosage: _____

Time of day to be Given: _____ Duration: _____

Route of Medication: _____

Reason (unless confidential): _____

Side Effects to Watch For: _____

Special Instructions: _____

Licensed Practitioner Name: _____

Address: _____ Phone: _____

Practitioner's Signature: _____ Date: _____



Emergency Information & Authorization for Treatment and Transportation

Child's Name _____

Nickname _____ Date of Birth _____

Home Address _____
Street City/State Zip

Home Phone _____

Parent/Guardian Name _____

Cell Phone _____ Work Phone _____

Employer _____

Employer Address _____
Street City/State Zip

Parent/Guardian Name _____

Cell Phone _____ Work Phone _____

Employer _____

Employer Address _____
Street City/State Zip



Alternate Emergency Contact:

(1) _____
Name Relationship Phone Number

Address _____
Street City/State Zip

(2) _____
Name Relationship Phone Number

Address _____
Street City/State Zip

Additional Person Authorized to Pick up Child:

(1) _____
Name Relationship Phone Number

Address _____
Street City/State Zip

(2) _____
Name Relationship Phone Number

Address _____
Street City/State Zip



Health Care Contacts:

Physician Name	Address	Phone Number
----------------	---------	--------------

Dentist Name	Address	Phone Number
--------------	---------	--------------

Hospital Name	Address	Phone Number
---------------	---------	--------------

Allergies/Reactions

Chronic Illnesses/Special Needs

Medications

Insurance Provider / Name of Insured / Group Number

Authorization for emergency medical care and transportation: In the event of an emergency, I hereby give my permission for child care staff to access emergency medical services for my child, including transport to the nearest health care facility, to receive emergency medical or surgical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport.

Parent/Guardian Signature	Date
---------------------------	------

Parent/Guardian Signature	Date
---------------------------	------



Home Language Survey

Monument View Montessori Charter School needs to know the language(s) spoken and heard at home by each child. The information allows us to provide the best instruction possible for all students. Please answer the following questions.

Child's Legal Name: _____

Age: _____ Gender: _____

1. Which language did your child first learn to speak? _____

2. What language does your child use most often at home? _____

3. What language do you most often use to speak to your child? _____

4. In what country was your child born? _____

5. If your child was not born in the USA, what date did they enter the USA? _____

Student's Ethnicity/Race (choose one or more)

American Indian or Alaskan Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Other Pacific Islander White

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date



Preventive Medication Authorization Form

I give Monument View Montessori Charter School permission to help my child, _____
_____, use the following items at school (please check the items you are authorizing):

- Sunscreen
- Bug Spray
- Chapstick

Please understand that all of the items listed above must be provided by the family and must be labeled with your child's name.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____



Request for Records

Today's Date: _____

Child's Legal Name: _____ DOB: _____ Gender: M F

I hereby authorize (school most recently attended), _____,

(address)

(phone number)

to release all school records including, but not limited to: academics, testing, health records, discipline, attendance, special services, and any other relevant documents to Monument View Montessori Charter School.

Has the above-mentioned student ever been suspended? Yes No

If Yes, please explain: _____

Has the above-mentioned student ever been expelled or recommended for expulsion? Yes No

If Yes, please explain: _____

Has the above-mentioned student ever been retained? Yes No

If Yes, please explain: _____

Has the student received any previous testing, evaluations or services in any of the following areas?

___ IEP Disability Area: _____

___ Gifted and Talented

___ Psychological

___ Counseling

___ 504 Services

___ READ Plan

___ Other _____

False information on this form may jeopardize the student's enrollment in school

Parent/Guardian Signature: _____ Date: _____

According to the Family Educational Rights and Privacy Act, a student's education records can be disclosed without parental consent to school officials of another school or school system where the student seeks to enroll.

Please send all records to:

Monument View Montessori Charter School
1956 US-6 Fruita, CO 81521
(970) 858-3798



Preschool Financial Policy

Enrollment and Withdrawal

Enrollment in Monument View Montessori Charter School (MVMCS) should be viewed as long term in nature. Children should be given the opportunity to complete the educational cycles of the program. At the time of enrollment, an enrollment contract must be signed stating that the child will be attending MVMCS for the full academic year. Once signed, the parent is then responsible for payment of the total tuition for that period of time. No reduction will be made in tuition for vacation time taken or for time the child is absent due to illness. _____ initial

The enrollment contract can be broken only if the child's family is relocating, if the child has a prolonged illness, or if the teacher agrees that it is in the best interest of the child to be transferred to another school. In all cases, a 30-day written notice must be given to the school administrator before the child is withdrawn. Otherwise, the parent is responsible for the balance of tuition owed for the school year. The tuition deposit will not be refunded for children withdrawn before the end of the school year. A 30-day notice must be given for any withdrawal prior to the beginning of the fall semester. No refund of registration/materials fees or tuition will be given if a child is withdrawn after the enrollment contract is submitted. _____ initial

Enrollment Fees

There is a \$100 nonrefundable registration/materials fee due at the beginning of each school year. _____ initial

Tuition Payment Dates

- Full Year Payments are due August 1st
- Quarterly Payments are due August 1st, November 1st, February 1st, and April 1st
- Monthly Payments are due the 1st of each month

If the due date falls on a weekend, payment is due on the Friday before.

Monthly payments are due on the 1st of each month, and are considered delinquent on the 5th of the same month. Any delinquency of 5 days will result in a \$20.00 late fee per child. Delinquencies over 20 days will result in withdrawal of your child. No child may enter the new school year, or have their position for one of these sessions guaranteed, if an outstanding balance remains unpaid. A \$30 charge is assessed on all returned tuition checks. Any additional program charges, such as additional extended care, must be paid to MVMCS within 5 days of receiving an invoice.



I have read, understand and agree to abide by MVMCS's financial Policy. This is a written contract; by signing you are taking full financial responsibility for the annual tuition.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date



2020/2021 Tuition and Fee Structure

Preschool Program (5-day week only)

Preschool*	
Half-Day	Full-Day
8:30am – 12:00pm	8:30am – 2:45pm 8:30am – 2:00pm on Fridays
\$5,000.00 annually	\$ 7,400.00 annually
\$520.00 monthly	\$760.00 monthly

Free tuition for full-day preschool is available on the basis of need for eligible children. Contact our office at (970) 858-3798.

Kindergarten and Elementary (1st – 5th Grade) Programs

Kindergarten and Elementary
8:30am – 2:45pm 8:30am – 2:00pm on Fridays
Tuition-free

Before/After School Care

Monument View Montessori Charter School is pleased to offer Before and After School Care on the school premises, extending the school’s operating hours to 7:30am – 5:30pm.

Before Care	After Care
7:30 – 8:30am	3:00 – 5:30pm 2:00 – 5:30pm on Fridays
\$5/day	\$225 per month, per student

A minimum of 8 students must be registered for after care each month, otherwise after care will not be offered for the month. Before and after care tuition is due at the beginning of the month.

Activity & Materials Fees

Activity & Materials Fees are used for consumable materials the children use throughout the year.

Preschool: Materials Fee – \$100 each school year

Kindergarten and Elementary: Activity & Materials Fee – \$200 each school year

If this fee provides a financial hardship or you qualify for the Free or Reduced Lunch program, please contact our office at 970-858-3798.

General Health Appraisal Form

Parent: Please complete

Child's Name: _____ Birthdate: _____

Allergies: None Describe: _____

Type of Reaction: _____

Diet: Breast Fed Formula: _____ Age Appropriate

Special Diet: _____

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

Parent or Legal Guardian Signature Date: _____
Authorization expires 365 days after this date

Health Care Provider: Please complete after parent section has been completed

Date of Last Exam: _____ Recent Weight: _____ **HCT: _____ ** B/P: _____ **Lead Level: _____

Physical Exam: Normal Abnormal (see explanation of significant health concerns:)

Significant Health Concerns: None Reactive Airways Disease Seizures Diabetes Developmental Delays

Vision Hearing Hospitalizations Severe Allergies Other (dental, nutrition, behavior, etc.) _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

Current Medications/Special Diet: None Describe: _____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever (mark only one product: max. 3 consecutive days without additional medical authorization)

Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:

Dose _____ See attached Dosage Schedule from our office

OR

Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:

Dose _____ See attached Dosage Schedule from our office

Immunizations: Up-to-date See attached immunization record Administered today: _____

Signature:

Next Well Visit: Per AAP Guidelines* or Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) Date

Office Stamp: Or write Name, Address, Phone Number

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** Required by Head Start programs only per state EPSDT schedule

© Copyright 2004 Colorado Chapter of the American Academy of Pediatrics.

MVMCS 2019-2020 Family Economic Data Survey

Complete one survey per household. Please use a pen (not a pencil).

STEP 1 List all student's attending **[Insert District Name]** (if more spaces are required for additional names, attach another sheet of paper)

Student's First Name	MI	Student's Last Name	No Income	Birth Date					Grade	Check all that apply. Read Federal Economic Data Survey Application Instructions for more information.	Foster Child	Head Start	Runaway	Homeless	Migrant
				M	M	D	D	Y			Y				

STEP 2 If household members (including you) currently participate in one of the following assistance programs: SNAP, TANF, or FDPIR list the case number below.

Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF/Colorado Works – Basic Cash Assistance or State Diversion), or Food Distribution Program on Indian Reservations (FDPIR). **Provide case number and skip to Step 4.**

SNAP Case Number	TANF Case Number	FDPIR Case Number

STEP 3 Report income for ALL household members (Skip this step if you provided a case number in STEP 2)

A. Student Income

Please include the **TOTAL** income, if any, received by all students' listed above.

Student Income	How Often?				
	Weekly	Bi-Weekly	2x Month	Monthly	Annually
\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. All Other Household Members (including yourself)

List all other household members not listed in Step 1 (including yourself) even if they do not receive income. For each household member listed, if they do receive income, report **TOTAL GROSS (BEFORE TAXES AND OTHER DEDUCTIONS)** for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying that there is no income to report.

Names of Other Household Members (First and Last)	Earnings from Work	How Often?					Public Assistance/Child Support/Alimony	How Often?					Pensions/Retirement/All Other Income	How Often?				
		Weekly	Bi-Weekly	2x Month	Monthly	Annually		Weekly	Bi-Weekly	2x Month	Monthly	Annually		Weekly	Bi-Weekly	2x Month	Monthly	Annually
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Household Members (Students' and Adults)

STEP 4 Contact information and adult signature. Mail signed and completed application to: MVMCS

"I certify (promise) that all information on this survey is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal, State, and/or Local Education Program funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose access to waivers of fees and the district/school may lose funding, and I may be prosecuted under applicable State and Federal laws."

Mailing Address or PO Box		Apt. # or Lot #		City		CO	Zip Code		Email Address		
Phone		SIGNATURE of Adult Household Member				Printed First and Last Name of Signer				Today's Date	

STEP 5 Release of Information

The information provided on this survey will be used in conjunction with state educational programs and may be shared with Medicaid or State Children's Health Insurance Program (SCHIP) offices to seek enrollment of children into the above programs. Also, if your students qualify this information may be shared with the school/district for the purpose of waiving certain school/district program fees that your child(ren) might otherwise be required to pay. The school/district is not permitted to share your information with anyone else. You are not required to consent to the release of your information; this will not affect your student(s)' eligibility for school meals. *Your information WILL be shared unless you check one of the boxes below.*

Do NOT share my information with any programs
 Do not share my information with the programs I have checked:
 Medicaid/SCHIP
 List Specific Program
 List Specific Program
 List Specific Program
 List Specific Program

DISTRICT USE ONLY. DO NOT WRITE BELOW THIS LINE.

Annual Income Conversion: Weekly x 52; Bi-Weekly x 26; 2 Times per Month x 24; Monthly x 12

Survey Type:

Total Household Income: \$ _____ Household Size: _____
Household Income Frequency - Weekly Bi-Weekly 2x/Month Monthly Annually

Categorical Eligibility - SNAP FDPIR TANF Foster
 Homeless/Migrant/Runaway/Head Start

Survey Status:

Approved - Free Reduced

Denied - Over Income Guidelines Incomplete/Missing: _____

Notes: _____

Determining Official Signature:

Approval/Denial Date:

Notification Sent: