SECRET GARDEN
MONTESSORI

1110 Harrison Street • Frenchtown NJ 08825
Phone (908) 628-9639 • Fax (908) 996-9801 • www.secretgardenmontessori.org

Dear families,

Welcome! We thank you for choosing Secret Garden Montessori. Enclosed you will find a comprehensive registration packet. Once we receive this packet, your enrollment agreement and all necessary tuition deposits, your child's placement in the program will be secured.

As a licensed childcare center in New Jersey, we are obliged to provide you, as the parent of a child enrolled at our center, with our Parent Handbook that includes the informational statement and our contagious disease, staff discipline & child suspension/expulsion policies.

The informational statement highlights, among other things: your rights to visit and observe our center at any time without having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Division of Youth and Family Services (DYFS).

Please read the Parent handbook carefully and if you have any questions feel free to contact our office.

We have included a registration checklist of required documents below for your convenience:

1. Emergency medical form and immunization records or letter of religious objection.*
   Please note Children under 59 months of age are required to receive a flu shot annually between the months of September-December. Record of updated vaccination must be submitted as soon as the flu shot has been received.

2. Universal Child Health record completed and signed by your child's doctor.

3. Receipt of information form

4. Program selection form

Thank you for choosing our school. We are glad to have you in the community!

Sincerely,

Rosalie Skakum

Rosalie Skakum
Administrative Head

Secret Garden Montessori 2020-21 Program Registration form

Child's name: _____ DOB: _____

Sprouts Infant/Toddler Program

___ Half Day ___ Full Day

Circle all that apply*

M T W TH F

*Subject to availability/ Two day minimum/ Consecutive days **strongly** recommended

Primary Program

___ Half Day ___ Full Day ___ 3 day option*

*Available for 1st semester only/

Before Care ONLY (7:00-8:30am): Circle desired days

M T W TH F

After Care ONLY (3:00-5:30pm): Circle desired days

M T W TH F

Please complete and return to our office with a $75 registration fee. Upon receipt of this registration, SGM will draft an enrollment agreement to be signed by both parties and returned with a one-month deposit. At that time, your child's spot in the program for the 2020-21 school year will be confirmed.

Parent #1 signature: _____ Date: _____

Parent #2 signature: _____ Date: _____

Consent to Emergency First Aid, Medical Treatment & Transportation

In the event of medical emergency, I hereby grant permission for administration of first aid, transportation to a hospital, if deemed necessary, and treatment by a physician, or other medical personnel for the following Secret Garden Montessori student during the 2020-21 summer and school year:

Student's Name _____ Date of Birth: _____

Parent's signature_____ Date: _____

Mailing Address: _____ Home Phone: _____

	Custodial Parent #1	**Custodial Parent #2**
Name		
Cell Phone		
Work Phone		
Work Address		
Email		
Is there a non-custodial parent?	____ yes ___ no	If yes, has he/she been denied or limited access to child by court order? (Please include copy of court order if so.)

Alternate emergency contacts ***must be able to drive & assume temporary care of child.***

	#1 Alternate Emergency Contact	**#2 Alternate Emergency Contact**
Name		
Phone		
Address		
Relationship to Child		

Child's Physician:	City, State & Phone #:
Child's Dentist:	City, State & Phone #:
Insurance company:	Policy #:
Child's SSN:	
Regular medications:**	
Medicine Allergies:**	
Food Allergies**	
Other Allergies:**	

***Please explain details and any instructions on other side of paper*

RECEIPT OF INFORMATION TO PARENTS

Name of child: _____

Name of Parent/Guardians(s): _____

I have received and read the copy of the Information to Parents Statement prepared by the Bureau of Licensing in the Division of Youth and Family Services and included in the Secret Garden Montessori Community Handbook. Additionally I have reviewed Secret Garden Montessori's contagious disease & discipline/suspension/expulsion and release of children policies as required by the Bureau of Licensing.

Signature of Parent: _____ Date _____

AUTHORIZATION TO USE PHOTOGRAPHS & CHILD WORK

I, _____, hereby authorize Secret Garden Montessori to freely use, reproduce, and/or publish photographs of my child and/or his/her work in press releases, brochures & other promotional materials, and on the Secret Garden Montessori website, newsletter and on social media, both while they are enrolled at the school and afterwards. This authorization shall remain in place unless specifically rescinded later.

Name of child: _____

Signature of Parent: _____ Date: _____

BLANKET PERMISSION SLIP FOR WALKS DURING SCHOOL DAY

My child, _____, has permission to be escorted by Secret Garden's faculty/staff and parents on walks in the neighborhood, including but not limited to daily play/lunch at Old Frenchtown Field and visits to our flower garden.

Signature of Parent: _____ Date: _____

PERMISSION TO ADMINISTER SUNBLOCK

Please initial here to signify consent to teacher application of sunblock/lotion (supplied by parents) when deemed necessary during outdoor playtime:

Signature of Parent: _____ Date: _____

***APPENDIX H* UNIVERSAL CHILD HEALTH RECORD**			*Endorsed by: American Academy of Pediatrics, New Jersey Chapter* *New Jersey Academy of Family Physicians* *New Jersey Department of Health*		
SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name *(Last) (First)*		Gender Male Female		Date of Birth / /	
Does Child Have Health Insurance? Yes No			If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name		Home Telephone Number **( ) -**		Work Telephone/Cell Phone Number **( ) -**	
Parent/Guardian Name		Home Telephone Number **( ) -**		Work Telephone/Cell Phone Number **( ) -**	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date			This form may be released to WIC. Yes No		
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:			Results of physical examination normal? Yes No		
Abnormalities Noted:			Weight *(must be taken within 30 days for WIC)*		
Height *(must be taken within 30 days for WIC)*					
Head Circumference *(if <2 Years)*					
Blood Pressure *(if >3 Years)*					
IMMUNIZATIONS			Immunization Record Attached Date Next Immunization Due:		
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		None Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		None Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		None Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		None Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		None Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		None Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		None Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		None Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	**Date Performed**	**Record Value**	**Type Screening**	**Date Performed**	**Note if Abnormal**
Hgb/Hct			Hearing		
Lead: Capillary Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

SECRET GARDEN MONTESSORI

APPLICATION FOR SPROUTS AND PRIMARY PROGRAMS

LEVEL

___ SPROUTS (18 months-2.5 yr)
Please circle: M T W TH F
___ 1st YEAR PRIMARY (Age 3-4)
___ 2ND YEAR PRIMARY (Age 4-5)
___ 3RD YEAR PRIMARY (Age 5-6)

EXTENDED PROGRAMS

___ BEFORE CARE (7-8:30am)
Please circle: M T W TH F
___ AFTER CARE (3-5:30pm)
Please circle: M T W TH F
___ VACATION CARE
___ SUMMER PROGRAM

START DATE

___ IMMEDIATE OPENING
___ SUMMER 20___
___ FALL 20___

APPLICANT INFORMATION

_____ ___ MALE ___ FEMALE
LAST NAME FIRST NAME MI

_____ _____YRS _____ MTHS
DATE OF BIRTH PLACE OF BIRTH PRESENT AGE

FAMILY INFORMATION

_____ __ Mr. __ Mrs. __ Dr. __ Ms.
PARENT/GUARDIAN #1 LAST NAME FIRST NAME MI

HOME ADDRESS CITY STATE/ZIP COUNTY

HOME PHONE CELL PHONE EMAIL ADDRESS

EMPLOYER NAME OCCUPATION/TITLE WORK PHONE AND EMAIL

_____ __ Mr. __ Mrs. __ Dr. __ Ms.
PARENT/GUARDIAN #2 LAST NAME FIRST NAME MI

HOME ADDRESS CITY STATE/ZIP COUNTY

HOME PHONE CELL PHONE EMAIL ADDRESS

EMPLOYER NAME OCCUPATION/TITLE WORK PHONE AND EMAIL

PARENTS/GUARDIANS ARE: ___ MARRIED ___ SEPARATED ___ DIVORCED ___ SINGLE ___PARTNERS ___WIDOWED

STEPPARENT NAME (IF APPLICABLE) _____

WITH WHOM DOES THE APPLICANT LIVE? ___ BOTH PARENTS ___ MOTHER ___ FATHER ___ OTHER

PLEASE LIST OTHER CHILDREN IN YOUR FAMILY

NAME _____ DATE OF BIRTH _____ GRADE _____ SCHOOL _____

NAME _____ DATE OF BIRTH _____ GRADE _____ SCHOOL _____

NAME _____ DATE OF BIRTH _____ GRADE _____ SCHOOL _____

NAMES AND RELATIONSHIPS OF ANY FAMILY MEMBERS WHO HAVE ATTENDED SGM

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

SCHOOL/CHILD HISTORY INFORMATION

PRESENT SCHOOL _____ DATES OF ENROLLMENT _____
ADDRESS _____
PRINCIPAL/DIRECTOR _____ PHONE _____

PREVIOUS SCHOOL _____ DATES OF ENROLLMENT _____
ADDRESS _____
PRINCIPAL/DIRECTOR _____ PHONE _____
REASON FOR CHANGING SCHOOL (IF APPLICABLE) _____
_____

HAS YOUR CHILD EVER HAD ANY EDUCATIONAL OR PSYCHOLOGICAL DIAGNOSTIC EVALUATIONS? ___ Y ___ N

HAS YOUR CHILD RECEIVED/OR IS RECEIVING ANY EARLY INTERVENTION OR SPECIAL SERVICES? ___ Y ___ N

IF YES, PLEASE DESCRIBE THE NATURE OF THESE SERVICES.

_____
_____
_____

DOES YOUR CHILD HAVE ANY PHYSICAL LIMITATIONS OR ALLERGIES? ___ YES ___ NO

DOES YOUR CHILD HAVE ANY SIGNIFICANT MEDICAL HISTORY WE NEED TO BE AWARE OF? ___ YES ___ NO

IS YOUR CHILD CURRENTLY UNDER MEDICAL CARE OR TAKING ANY MEDICATION? ___ YES ___ NO
IS THERE ANY MEDICAL, BEHAVORIAL, BIRTH OR ENVIRONMENTAL HISTORY THAT WILL HELP US UNDERSTAND YOUR CHILD BETTER? PLEASE DESCRIBE.

_____
_____
_____
_____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A SEPARATE SHEET WITH DETAILS AND IF RELEVANT, REQUEST COPIES OF REPORTS TO BE SENT TO US FOR YOUR CHILD'S FILE

PLEASE ANSWER THE FOLLOWING QUESTIONS. FEEL FREE TO USE A SEPARATE SHEET IF MORE ROOM IS NEEDED. OUR GOAL IS TO LEARN MORE ABOUT YOUR CHILD AND FAMILY TO DETERMINE WHETHER SGM IS A GOOD FIT.

WHAT HAS DRAWN YOU TO SGM? WHY DO YOU FEEL IT WOULD BE A GOOD FIT FOR YOUR CHILD?

_____
_____
_____

WHAT ARE YOUR EXPECTATIONS/GOALS FOR YOUR CHILD AT SGM?

_____
_____
_____

PLEASE CIRCLE ALL THAT APPLY:

IS YOUR CHILD; ADOPTED IN FOSTER CARE UNDER LEGAL GUARDIANSHIP

ARE THERE PERTINENT CUSTODY ARRANGEMENTS? YES NO

IF YES, PLEASE DESCRIBE: _____

HAS YOUR CHILD EXPERIENCED SEPARATION FROM THE PRIMARY CAREGIVER BEFORE? YES NO

ARE THERE OTHER CAREGIVERS WITH WHOM YOUR CHILD SPENDS A LOT OF TIME? YES NO

IF YES, PLEASE DESCRIBE (I.E. FREQUENCY, NATURE OF RELATIONSHIP,ETC)

_____
_____

IS YOUR CHILD POTTY TRAINED? NOT AT ALL PARTIALLY COMPLETELY

HOW OFTEN DOES YOUR CHILD NAP? DAILY OFTEN RARELY

DESCRIBE YOUR CHILD'S APPETITE. EATS WELL EATS POORLY LIKES/DISLIKES VARIETY

IS YOUR CHILD; RIGHT-HANDED LEFT-HANDED NOT DISPLAYING A PREFENCE

_____
_____
_____

PLEASE TELL US A BIT ABOUT YOUR CHILD'S PERSONALITY, DISPOSITION AND SOCIAL INTERACTIONS.

_____
_____
_____
_____
_____

IF THERE ARE ANY ADDITIONAL THINGS YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD, PLEASE SHARE THEM WITH US ON A SEPARATE SHEET.

AUTHORIZATION FOR THE RELEASE OF RECORDS

NAME OF APPLICANT _____

PRESENT SCHOOL _____

ADDRESS

_____

TELEPHONE _____ FAX _____

ON BEHALF OF MY CHILD, _____, WHO IS PRESENTLY ENROLLED AS A STUDENT AT YOUR SCHOOL, I HAVE APPLIED FOR ADMISSION TO SECRET GARDEN MONTESSORI BEGINNING WITH THE TERM STARTING _____, 20 _____.

I HEREBY AUTHORIZE YOU TO RELEASE THE FOLLOWING:

- A COMPLETED COPY OF HIS/HER FILE
- A TRANSCRIPT OF HIS/HER ACADEMIC RECORD
- HEALTH FORMS
- RELEVANT TEST SCORES
- TEACHERS' COMMENTS AND OBSERVATIONS OF HIS/HER OVERALL DEVELOPMENTAL PROGRESS

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

PLEASE FORWARD ALL RECORDS TO:
SECRET GARDEN MONTESSORI
ATTN: HEAD OF SCHOOL
1110 HARRISON STREET
FRENCHTOWN, NJ 08825
PH 908-628-9639
FAX 908-996-9801

THIS APPLICATION IS REGARDED AS A FORMAL REQUEST FOR CONSIDERATION OF YOUR CHILD AS A POTENTIAL STUDENT AT SECRET GARDEN MONTESSORI AND AS AUTHORIZATION FOR OUR OFFICE TO OBTAIN TRANSCRIPTS AND RECOMMENDATIONS FROM PREVIOUS SCHOOLS.

UPON RECEIPT OF THIS APPLICATION AND FEE, YOUR CHILD WILL BE PLACED IN OUR ACTIVE APPLICANT POOL. OUR HEAD OF SCHOOL WORKS WITH OUR ADMISSIONS COMMITTEE TO REVIEW ALL APPLICATIONS AND MAKE OUR FINAL ENROLLMENT DETERMINATIONS. YOU WILL BE NOTIFIED OF OUR DECISION WITHIN 30 DAYS OR LESS FROM THE DATE OF YOUR APPLICATION SUBMISSION. IF ACCEPTED, YOU WILL ALSO RECEIVE AN ENROLLMENT AGREEMENT TO BE SIGNED AND SUBMITTED PROMPTLY.

SECRET GARDEN MONTESSORI DOES NOT DISCRIMINATE ON THE BASIS OF AND ADMITS STUDENTS OF ANY RACE,COLOR, NATIONAL AND ETHNIC ORIGIN, FAITH, GENDER, GENDER IDENTITY, SEXUAL ORIENTATION, PHYSICAL DISABILITY OR ANY OTHER CHARACTERISTIC PROTECTED BY LAW, TO ALL THE RIGHTS, PRIVILEGES, PROGRAMS AND ACTIVITIES GENERALLY ACCORDED OR MADE AVAILABLE TO STUDENTS AT THE SCHOOL.

SECRET GARDEN MONTESSORI RESERVES THE RIGHT TO AMEND OR WITHDRAW ANY PROGRAM FOR WHICH THERE IS NOT SUFFICIENT ENROLLMENT.

PLEASE SHARE WITH US THE NAME AND ADDRESS OF THE INDIVIDUAL(S) WHO WILL ASSUME FINANCIAL RESPONSIBILITY FOR TUITION (IF OTHER THAN YOURSELF):

NAME _____

ADDRESS _____

_____

PHONE _____

SIGNATURE OF PARENT/GUARDIAN #1 _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN #2 _____ DATE _____

PLEASE SUBMIT THIS APPLICATION ALONG WITH A $75 NON-REFUNDABLE APPLICATION FEE TO:

SECRET GARDEN MONTESSORI
1110 HARRISON STREET
FRENCHTOWN, NJ 08825

PH (908) 628-9639
FAX (908) 996-9801
EMAIL: INFO@SECRETGARDENMONTESSORI.ORG

THANK YOU FOR YOUR INTEREST IN OUR SCHOOL!