Pinnacle Montessori Academy

Reach for the Stars

2025-2026 Enrollment Forms

Child's Full Name	Date of Birth	Gender ☐ M ☐ F
Child's Full Address		
Primary Contact Name	Primary Contact Phone No.	

I hereby authorize Pinnacle Montessori Academy to allow my child to leave Pinnacle Montessori **ONLY** with the following people. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

Name of Emergency Contact (if Parents cannot be reached)		Relationship to Child
Emergency Contact Full Address		Emergency Contact #: Driver's License Number:
Name of Authorized Pick-Up	Name of Authorized Pick-Up	Name of Authorized Pick-Up
Phone #: Driver's License #:	Phone #: Driver's License #:	Phone #: Driver's License #:
Relationship	Relationship	Relationship

Parent Information

Mother/Guardians Name:	Marital Status: Driver's License #:
Home Address:	Email Address:
Cell No.:	Home No.:
Employer:	Work No.:
Father/Guardians Name:	Marital Status: Driver's License #:
Home Address:	Email Address:
Cell No.:	Home No.:
Employer:	Work No.:

Date of Admission: **Start Date:**

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Please make a selection for all the below. (A selection MUST be made for all sections in order to enroll)

1. **Receipt of written operational policies (Parent Handbook)**:
   I ☐ acknowledge receipt of the facilities operational policies including those for discipline and guidance contained in the Pinnacle Montessori Academy Handbook.

2. **Transportation**: I hereby ☐ give ☐ do not give
   - consent for my child to be transported and supervised by the operations employees –
     ☐ for emergency care ☐ on field trips ☐ to and from school.

3. **Field Trips and Water Activities:** I hereby ☐ give ☐ do not give
   - consent for my child to participate in field trips and/or water activities.
   Parents comments:

4. **Buggy Ride and Ointment Cream**: I hereby ☐ give ☐ do not give
   - consent to Pinnacle Montessori Academy to apply any ointment, rash cream and/or sun lotion that I have provided.
   - consent to Pinnacle Montessori Academy for my child to ride in the buggy while at school.

5. **Snacks**: I understand snacks will be provided for my child while in care.
   I hereby ☐ give ☐ do not give permission for the facility to serve the following to my child:
   ☐ AM Snack ☐ PM Snack ☐ Late PM Snack

6. **Attendance**: My child will normally be in care on the following days and times:

Mondays	from:	to:
Tuesdays	from:	to:
Wednesdays	from:	to:
Thursdays	from:	to:
Fridays	from:	to:

Authorization for Emergency Medical Attention (Must include precise locations; cannot say 'closest' or 'nearest'.)

In the event I (parent/guardian) or the Emergency Contact cannot be reached to make arrangements for emergency medical care, I authorize the facility to take my child to:

Name of Physician:	Address:	Phone Number:
Name of Emergency Medical Care Facility:	Address:	Phone Number:

I give consent for the facility to secure any and all necessary emergency medical care for my child.	_____ Signature of Parent or Legal Guardian

School Age Children (Only necessary for children enrolled in Public School.)

My child attends the following school:

_____

Name of School Address Phone No.

☐ His/her immunization record is on file at the school and all required immunizations and/or tuberculosis tests are current.
☐ Vision and Hearing screening records are also on file.

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Vision & Hearing Testing (Only necessary for children 4 years old and up.)							
Vision	R 20/_____		L 20/_____				☐ Pass ☐ Fail
_____ Signature of Professional			Date				
Hearing	1000 Hz		2000 Hz		4000 Hz		☐ Pass ☐ Fail
	R	L	R	L	R	L	
_____ Signature of Professional			Date				

Admission Requirement/Wellness Check (If your child does not attend pre-kindergarten or school away from PMA, a statement or signature from your health care professional and immunization record must be presented when your child is admitted to the school. **All documentation must be in prior to your child's first day.**

1. **Health-Care Professional's Statement (A)**: I, _____, have examined the child within the past year and find that he/she is able to take part in the child-care program.

_____
Health-Care Professional's Signature Address Phone No.

2. ☐ **Health-Care Professional's Statement (B)**: A signed and dated copy of a health-care professional's statement is attached.

3. **Provided Immunization Record**:
I ☐ have provided the childcare operation with a copy of my child's most current immunization record.

_____
Parent or Legal Guardians Signature Date

Allergies & Illnesses

List **any** special problems that your child may have such as **allergies and reactions**, **existing illnesses**, **previous serious illnesses & hospitalizations during the past 12 months, any medications prescribed for long-term continuous use** and any other information which caregivers should be aware of. **If your child has a food allergy, documentation is required from your health care provider. (Form is attached)**

_____

Do you have an asthma action plan in place with your doctor? ☐ Yes ☐ No
If so, please provide a copy for the school. Copy received: _____

*Please note: Per Texas Department of Family and Protective Services Minimum Standards, you MUST have a doctor's statement on file with Pinnacle Montessori describing any dietary restrictions such as food allergies or reactions. This statement should include what foods to avoid and possible substitutes for that food. Your health care provider can email this statement to the school director.

Parent Signature: **Today's Date:**

Child's Special Care Needs (Check all that Apply

- ☐ Environmental allergies Limitations or restrictions on child's activities
- ☐ Food intolerances Reasonable accommodations or modifications
- ☐ Existing illness Adaptive equipment (include instructions below)
- ☐ Previous serious illness Symptoms or indications of complications
- ☐ Injuries and hospitalizations (past 12 months)
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment (include instructions below)
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use
- ☐ Other

Explain any needs selected above:

Photo Media Release Form

Please check the appropriate boxes below for PMA photo/media authorization release/no names will be released

Facebook	_____Yes	_____No
Marketing	_____yes	_____No

Parent Signature: **Today's Date:**