

KAMPALA MONTESSORI SCHOOL

P.O. BOX 12111 Kampala, Uganda

Email: Kmontessorischool2012@gmail.com

Phone: 256 -753-979084 / 256 -785-979084

Website: www.kampalamontessorischool.com

“Education for life”

ADMISSION FORM for 3 - 6 years Old; 20..... SCHOOL YEAR. DATE/..... /20.....

--- Full day arrival 7:30am --- 4pm

---Half day arrival 7:30am--- 12:30pm

Child's Name (First).....(Middle).....
(Last).....

Date of Birth/...../20.... Sex.....place of Birth.....City.....,.....

Country.....

Current AddressPhone
#.....

Father's

Name.....Occupation.....City.....Country.....
Firm.....Address.....

.....

Working HoursBusiness Phone

#.....

Mother's

Name.....Occupation.....City.....Country.....
Firm.....Address.....

.....

Working HoursBusiness

Phone.....

Marital

Status.....Guardians.....

PhysicianPhone

#.....

Address.....

.....

List of others we may contact in case we cannot contact you

(1)Name.....Phone

#.....

Address.....

.....

(2) Name.....Phone

#.....

Address.....

.....

Parent(s): Sign. (Male)..... (Female).....

Date/...../20.....

Guardian(s): Sign.(Male).....(Female).....

Date/...../20.....

Persons Authorized to pick up your child.

(1) Name.....Phone
#.....
Address.....
.....

(2) NamePhone
#.....
Address.....
.....

Names and ages of
siblings.....

If there is an unusual custody situation, explain
briefly.....

Does your child have a special physician or emotional
problems?.....

Is your child receiving treatment or medication regularly?
Explain.....
.....

How did you learn about our
school?.....

Has your child attended any other
preschool?.....which.....

Have you observed a Montessori class in
session?.....When?.....

Have you attended a Montessori Parent Orientation
course?.....When?.....

**Why are you choosing a Montessori
School?.....**
.....

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Parent(s): Sign. (Male)..... (Female).....

Date/...../20.....

Guardian(s): Sign.(Male).....(Female).....

Date/...../20.....

PREPRIMARY PROFILE SHEET

Date...../...../20.....

Child's Name..... Age..... Date of Birth.../.../20.....

Mother's Name.....Phone #.....

Father's Name.....Phone #.....

DEVELOPMENTAL HISTORY

Accidents.....

Illness.....

Allergies (food, sinus, hay fever, medication).....

Is your child taking any medication? () yes () No

Speech problems? () Yes () No

Hearing problem? () yes () No

Child's Health? () good () fair () poor

Any physical problems?.....

Chronic problems?.....

Dietary History (sensitive to certain food?).....

SCHOOL HISTORY

Other early childhood program? e.g. Sunday school, Parent Infant () yes () No

Where?.....

How long?.....

What do you think of his or her progress in school?.....

.....

Parent(s): Sign. (Male)..... (Female).....

Date/...../20.....

Guardian(s): Sign.(Male).....(Female).....

Date/...../20.....