



COUNTRY DAY SCHOOL
OF ARLINGTON
MONTESSORI PROGRAM
established 1959

Application for Admission 2019—2020

Please print

Student Information

Full Name: _____ Male Female

Preferred Name: _____ Age: _____ Birth Date _____ / _____ / _____

Racial/Ethnic Group (Optional): African American Asian Caucasian Multi Racial
 Hispanic Middle-Eastern Native American Other

Applying for: Academic School Year (Aug. 12, 2019— May 22, 2020)
 My child will attend Summer Program 2019

Academic School Year Class Schedule M T W TH F 8:15AM-3:30PM OR Half Day

Email addresses to be used for all school communication and billing purposes:

- Primary Email address: _____ Father Mother Other
- Secondary Email address: _____ Father Mother Other

Mother / Guardian Information

Dr. / Mr. / Mrs. / Ms. _____

Home Address _____

Phone: Cell _____ Home _____ Work _____

If you wish to receive text communication, provide your mobile service carrier: _____

Employer: _____ Occupation _____

Work Address _____

Father / Guardian Information

Dr. / Mr. / Mrs. / Ms. _____

Home Address _____

Phone: Cell _____ Home _____ Work _____

If you wish to receive text communication, provide your mobile service carrier: _____

Employer: _____ Occupation _____

Work Address _____

Parents / Guardians: Married Separated Divorced Widowed Unmarried

Who has legal custody of the child? _____

If parents/guardians do not live together:

Please indicate with whom the child lives: _____

Are both biological parents to receive evaluations, report card, or academic information via
Montessori Compass and/or email? Yes No

Additional Comments: _____

Sibling Information

Name _____ Age _____ School _____
 Name _____ Age _____ School _____
 Name _____ Age _____ School _____

Previous School Information

Last School Attended: _____ Principal/Teacher: _____
 School Address: _____ Dates Attended: _____

Health Information

ALLERGIES: No Yes EPI Pen provided: Yes No

Describe the child's health (including allergies, physical and/or medical considerations, recent illnesses) that may have affected, or may affect their performance in school: _____

Foods that my child should NOT eat: _____

Other Limitations: _____ No Limitations

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached during a medical emergency, I hereby give the staff at **Country Day School of Arlington** authorization to make arrangements for emergency medical care. I authorize emergency medical personnel or the person in charge to take my child to:

Physician: _____ Phone #: _____

Address: _____

Emergency/Medical Care **Facility:** _____ Phone #: _____

Address: _____

I give consent for the facility to secure any and all necessary medical care for my child.

 Parent/Guardian Signature

Dismissal Authorization

The following parents/guardians are authorized to pick-up my child (driver's license number/state must be listed for all individuals- no exceptions)

Mother / Guardian State & DL#:

Father / Guardian State & DL#:

DISMISSAL AND EMERGENCY CONTACT AUTHORIZATION: The following additional persons (2 minimum) are authorized to pick-up my child. These individuals may be contacted by the school in the event that a parent/guardian cannot be reached during an emergency (driver's license number/state must be listed for all individuals- no exceptions).

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

ADDITIONAL DISMISSAL AUTHORIZATION: The following additional persons are authorized to pick up my child (driver's license number/state must be listed for all individuals- no exceptions).

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)

* Name: _____ Relation: _____
DL#: _____ DL State _____ Cell # (_____)
Home#(_____) Work # (_____)



Authorization

I hereby give the staff at Country Day School of Arlington authorization: *(check all that apply and initial as requested)*

- * **PHOTOGRAPHY AND/OR QUOTE:** all students' photographs will be included in the internal school parent communication portal, Montessori Compass.
- * I hereby -give -do not give my consent for my child's photograph or quote to be used in advertisements and/or external marketing.
- * **WATER ACTIVITIES:** I hereby -give -do not give my consent for my child to participate in water activities. (These activities typically include sprinklers, slip-n-slide, water games and small kiddie pools.) All activities are with adult supervision.
- * **INSECT REPELLANT:** I hereby -give -do not give my consent for my child to receive insect repellant provided by either the parent or CDSA.
- * **SUNSCREEN:** I hereby -give -do not give my consent for my child to receive sunscreen provided by either the parent or CDSA.
- * **SNACK** I acknowledge that I will provide a DAILY snack and lunch or choose a lunch selection from the vendor chosen by the school. _____initial

Grandparent Information

MAIL SCHOOL MATERIAL May CDSA mail school material to the grandparents? Yes -No For
example: Invitations to Grandparents/Special Friends Day

* **Maternal** Grandparents _____

Address _____

* **Paternal** Grandparents _____

Address _____

Extended Day Program Agreement

2019 - 2020 Academic School Year

1. Extended Day is available on a drop in or discounted monthly agreement basis for before-school, after-school, and/or holiday care. I understand that I have accepted financial responsibility to pay the following:
 - * **Drop-in** care is available at a rate of 10¢ a minute between 7-8AM and/or 3:30-6PM.
 - * **Monthly Plans** are available for full-time and part-time schedules and are detailed in the chart titled *2019-20 Extended Day Rates*. Rates may also be viewed at www.cdsa.org.
 - * A **Full Extended Day Plan** option is available as a 10-month agreement for the Academic School Year (August 12, 2019 - May 22, 2020) which includes all available Extended Day (7-8AM, 3:30-6PM, and all Holiday Care) at a rate of \$250/month.
 - * **Holiday Care** is available by registration for select school holidays as indicated on the 2019-2020 Academic School Year Calendar. Holiday care is billed in addition to monthly fees unless enrolled in the Full Extended Day Plan. Holiday Care from 8:15AM-3:30PM is \$30. Extended hours are available on Holiday Care days from 7-8AM and 3:30-6PM at a rate of 10¢ a minute.
 - * With the exception of August, which will be prorated, I understand that monthly rates have been set according to the total number of days offered. In cases of abbreviated days of attendance, such as Winter Break, I understand that my fee will remain the same.
 - * Changes made to a monthly agreement after the 1st of any given month will not go into effect until the following month. Any changes to a plan must be submitted in writing on the *Extended Day - Change of Schedule* form obtained by request from Administration.
2. I understand that it is my responsibility to review my plan choice if I choose to enroll my child in an afterschool class. CDSA does not charge for Extended Day during the time of an afterschool class. An *Extended Day- Change of Schedule* form can be obtained from Administration- if an plan change is desired.
3. I understand that I, or any agent of mine, will need to sign my child out on the Procure touchscreen located in the school foyer and follow the prompts. If I fail to sign my child out I will be charged for care until 6PM.
4. I have been provided a copy of the CDSA 2019-20 school year calendar. **Please note: CDSA will not offer Extended Day on August 5, September 2, November 27, 28, 29, December 24, 25, 26, 31, January 1, March 13, and May 25.**

IMPORTANT INFORMATION: Extended Day cell phone: 817-253-9994
 Emergency: Joyce Hunt: 817-723-1860

INCLEMENT WEATHER: school closings broadcasted on NBC5, WFAA 8, and posted www.cdsa.org

Extended Day Agreement

Please refer to *EXTENDED DAY— INFORMATION & RATES* and select one of the three options below:

- Drop-In:** care as needed
- Monthly Plan:** the days / timings desired
- | | |
|------------------------|--------------------------------|
| MORNING from 7 to 8AM | M ___ T ___ W ___ TH ___ F ___ |
| AFTERNOON until 4:30PM | M ___ T ___ W ___ TH ___ F ___ |
| AFTERNOON until 6:00PM | M ___ T ___ W ___ TH ___ F ___ |

Full Extended Day Plan

I confirm that I have read and agree to the CDSA Extended Day Program Agreement.

Child's name: _____

Signature of Parent/Guardian _____ Date _____



- * To be in **compliance with the State of Texas**, all required CDSA Admission Documents must be on file in the CDSA office.
- * Please update your child’s health information, dismissal instructions, and contact information as needed. Immunization records must be updated and submitted regularly throughout the school year.
- * A non-refundable \$100.00 enrollment fee and a non-refundable \$500 tuition deposit must accompany all applications. Please charge Tuition Express

I have carefully reviewed the questions on the
RE-ENROLLMENT APPLICATION FOR ADMISSION to Country Day School of Arlington
 and have answered them fully and to the best of my knowledge.

Signature of Mother / Guardian	Printed Name	Date
Signature of Father / Guardian	Printed Name	Date

END OF APPLICATION

Please submit to :
 Country Day School of Arlington
 1105 W. Randol Mill Road
 Arlington, TX 76012
 Fax: 817-275-0263
 Email: admin@cdsa.org



Tuition Express Parent Authorization Agreement

CDSA offers you the convenience of **automatic tuition payments** through Tuition Express.

Tuition Express is encouraged for all school related expenses. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition and other school expenses have been paid on time. It is easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, please visit www.tuitionexpress.com.



2019—2020
Tuition Express

I authorize Country Day School of Arlington to withdraw sufficient funds to pay my child's:

- Regular school tuition and other school related fees that are due and payable
(Extended Day, Activity/Resource Fee)
- Regular school tuition only
- Summer program tuition only
 - Please process on the 20th of the month
 - Please process in one lump sum

Child's name: _____

Signature of Parent/Guardian

Date

Phone #

* Credit Cards accepted: Visa and Master Card





Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. ____ (initial) Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____		Phone # _____	
Cardholder Address _____	City _____	State _____	Zip _____
Account Number _____	Expiration Date _____	cvv # _____	
Cardholder Signature _____			Date _____

SECTION B (Bank Account)

Your Name _____		Phone # _____	
Address _____	City _____	State _____	Zip _____
Bank or Credit Union Name _____	Bank or Credit Union Address _____	City _____	State _____ Zip _____
Routing Transit Number (see sample below) _____	Account Number (see sample below) _____	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Authorized Signature _____			Date _____

For Official Use Only

Date Received
Employee Signature



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Medical Information & Consent Form

Child's name _____ Date of birth _____
 Father: _____ Main contact # _____
 Mother: _____ Main contact # _____
 Allergies _____ Asthma/Hay fever _____
 Medicines _____ Daily Medications _____

(Attach the prescription and dosage instructions for all medications to be administered by CDSA staff.)

Foods that the child should not eat _____
 Other _____
 Limitations (activities in which the child should NOT participate) _____
 Water Activity _____ Field Trips _____ Outdoor Sports/Games _____
 Other _____

I hereby give authority for the CDSA staff to authorize medical treatment for my child in the event that I cannot be reached to make arrangements for emergency medical attention at the time of an illness or accident.

Parent/Guardian Signature: _____ Date: ____/____/____

TO BE COMPLETED BY THE CHILD'S PHYSICIAN CDSA FAX: 817-275-0263

★Please attach immunization records or fill in the chart below. Physician signature and date required.

	DATE 1st dose	DATE 2nd dose	DATE 3rd dose	DATE 1st booster	DATE 2nd booster
Hepatitis B (HepB)	_____	_____	_____	_____	_____
Diphtheria, Tetanus, Pertussis (DTaP)	_____	_____	_____	_____	_____
Haemophilus influenza b (Hib)	_____	_____	_____	_____	_____
Pneumococcal (PCV)	_____	_____	_____	_____	_____
Inactivated Poliovirus (IPV)	_____	_____	_____	_____	_____
Influenza	_____	_____	_____	_____	_____
Measles, Mumps, Rubella (MMR)	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____
Hepatitis A (HepA)	_____	_____	_____	_____	_____
TB Test	Date: _____	Results: _____			

★Any vaccine exclusion for medical reasons requires physician documentation. If positive, physician statement is necessary for admission. Results from vision and hearing screening are required for students 4 years and older. Attach additional documentation if necessary.

Vision _____ Hearing _____

This child was examined by me on ____/____/____ and is physically able to participate in the school program. Exceptions are noted on the back of this form.

Physician's signature _____ Phone _____