Montessori Schools of Central Texas

Infant & Toddler Enrollment Application

SY 2026 – 2027

This information will be held confidential and only be released by signed consent of parent or guardian. Failure to provide complete and accurate medical or behavioral information for your child will be grounds for non-admission or dismissal from MSCT.

Date of Application: _____ Desired Start Date (month/year): _____

How did you hear about our school? _____

☐ **Infant Program (6 weeks to 18 months of age)**
Class hours: drop off and pick up anytime between 7 a.m. and 6 p.m.

☐ **Toddler Program (18 to 36 months of age)**
Class hours: 8:00 a.m.-2:30 p.m. School opens at 7:00 a.m. and closes at 6 p.m.

Student's Name _____ ☐ Male ☐ Female

Address _____ City _____ Zip _____

Home Phone _____ Date of Birth _____ Age _____

Primary Sponsor (Parent/Guardian)

Name & Title (Circle: Mr./Mrs./Ms./Dr.)_____ Work Phone _____

Address _____ City _____ Zip _____
(*if different from child*)

Email _____Place of Employment _____

Cell Phone _____ Preferred Phone _____

Secondary Sponsor (Parent/Guardian)

Name & Title (Circle: Mr./Mrs./Ms./Dr.)_____ Work Phone _____

Address _____ City _____ Zip _____
(*if different from child*)

Email _____Place of Employment _____

Cell Phone _____ Preferred Phone _____

Child lives with: ☐ both parents ☐ mother ☐ father ☐ step-parent ☐ other _____

Please fill out the reverse side to complete this application.

Please answer the following behavioral and medical questions:

Diet: [ ] Breastfeeding* [ ] Formula [ ] Soft Foods [ ] Solid Foods (*Select all that apply*)
*If breastfeeding during the day, when can the mother be expected at the school: _____

I understand that MSCT is not responsible for the nutritional value of meeting my child's daily food needs for meals or snacks I provide. (Initial) _____

Eating Habits: [ ] Good [ ] Poor **Toilet Learned**: [ ] Yes [ ] No

Sleeping Habits: [ ] Falls asleep easily [ ] Falls asleep with difficulty [ ] Wakes easily [ ] Wakes with difficulty [ ] Naps during the day: What times? _____

Check all that apply:
[ ] Allergies* (please list): _____
Listed food allergies require a physician's diagnosis and treatment plan to be submitted with enrollment paperwork.
[ ] Asthma [ ] Autism [ ] Feeding Difficulties [ ] Ear Infections [ ] Other: _____

Does your child have vision difficulties? _____ Does your child have hearing difficulties? _____

Does your child have speech difficulties? _____ Does your child attend speech classes? If yes, when and where? _____

Has your child been referred for testing for any learning difficulties? _____

Is your child presently under the care of a physician or therapist? _____ If so, why?
_____

Does your child take medication on a regular basis? _____ If so, list the medication, reason for treatment, and describe when your child takes it: _____

Does your child wear any special appliances or equipment which will be worn at school including dental appliances? _____

Are there any past or present family situations that could impact your child's attendance, behavior, or stress level? _____

I certify that the above information is complete and accurate to the best of my knowledge. If there are any changes during the school year, I understand that it is my responsibility to notify the school.

Signature of Parent/Guardian _____ Date _____