

APPLICATION OF INTEREST

Rev 1/23

Enrollment Year Applying for: **2023-2024** **2024-2025** **2025-2026** **2026-2027**

Time of Year Preferred: **Fall** **Mid-Year: List Month** _____

Program Applying for: **Toddler (12m-36m)** **Primary (3y-K)** **Elementary (1st-3rd / 4th-6th)**

Child's Name: _____

Last First Middle Nickname

Birth date: _____ **Gender:** _____ **Race:** _____ **Adopted:** **Yes** **No**

Home Address: _____

City, State & Zip: _____

Parent name: _____

Parent name: _____

Cell: _____

Cell: _____

Home email: _____

Home email: _____

Occupation: _____

Occupation: _____

Employer: _____

Employer: _____

Work phone: _____

Work phone: _____

Work email: _____

Work email: _____

Family Status: (Check all that apply)

Single **Parents divorced** **Father remarried**

Parents married **Parents separated** **Mother remarried**

Guardianship **Father deceased** **Mother deceased**

With whom is the child living? _____

Siblings: **Name:** _____ **Age:** _____ **School:** _____

Name: _____ **Age:** _____ **School:** _____

Name: _____ **Age:** _____ **School:** _____

Why are you considering Montessori for your child?

How did you become acquainted with Versailles Montessori School?

Internet Drove by Referral (who?) _____

Has your child attended a Montessori program before? Yes No

If yes, where? _____

What are your expectations regarding your child's learning experience at VMS?

Will your child attend VMS for:

Kindergarten? Yes No Undecided
Elementary? Yes No Undecided

Do you have any concerns about your child's development? Yes No If yes, please explain

Has your child received any screenings or services from a specialist? Yes No
If yes, for what concern? *Please attach the reports.*

Your child's present school or day care program: _____

Teacher: _____ School/Day care phone: _____

Current grade: _____

Parent Signature: _____ Date: _____

Family Questionnaire

rev 12/2021

Your responses on this questionnaire will help us learn more about your child. Please complete each item and return it with your completed Application of Interest form. There are no “right” or “wrong” answers to the questions.

Child’s Name: _____ Date of Birth: _____

What languages are spoken in the home: _____

General - Tell us about your experiences with and observations of your child.
Describe a typical weekday for your child.

Describe a typical weekend for your child.

What are two things your child likes to do best?

What are two things your child does not like to do?

What is your favorite thing to do with your child?

What are three words you feel best describe your child?

Are screens a part of your child’s daily routine? Yes No Hours per day:
Check examples that apply: When parents watch With siblings For entertainment

What is watched on screen time? What games are played?

Is your child responsible for regular household chores? Yes No
If yes, what are they?

Does your child stand back and observe or quickly engage in a new environment?

Does your child tolerate disruptions in their daily routine with ease or are they stressful?

How does your child deal with frustration?

Practical Life at Home - Tell us about your child's routines and general skills.

What is your child's normal bedtime? Where do they usually fall asleep (in their bed, in your arms, on the sofa...)?

What time does your child normally wake up in the morning?

Does your child normally take a nap? When? If so, how long do they normally sleep?

What does your child normally eat for breakfast?

What does your child like to eat most?

Are there any foods your child will not eat?

Does your child feed him/her self? Yes No

Does your child dress him/her self? Yes No Somewhat (Please explain)

Does your child use the toilet independently? Yes No
If not, please tell us where they are in this process. (e.g. able to undress, dress, able to wipe, tell you when they need to go, etc.)

Please tell us about your approach to discipline? (time-out, spanking, redirecting...)

Medical History

Were there any significant problems during pregnancy or directly following birth that might have an effect on your child's development (i.e. premature birth, low birth weight, etc)? __

Was your child more than 3 weeks premature? Yes No

Have you ever suspected that your child has vision problems? Yes No
If yes, please explain:

Have you ever suspected that your child has hearing problems? Yes No
If yes, please explain:

Has your child ever had trouble walking, climbing, reaching, holding on to things?
Yes No
If yes, please explain:

Does your child have allergies? Yes No
If yes, please explain:

Is your child presently on any medications? Yes No
If yes, please explain:

Does your child have frequent:
stomach aches bladder infections ear infections respiratory issues

Any serious accidents? Yes No
If yes, please explain:

Approximate age for: crawling _____ For how long before walking _____
Did your child primarily *army crawl* or crawl on *hands and knees*?

Child Development

How many words are in your child's vocabulary? _____

Are they speaking in sentences? Yes No

Is your child easily understood when speaking to others? Yes No

Can your child:

Use a spoon or fork for meal time? Yes No

Drink from an open cup with no sippy lid? Yes No

Express their thoughts or needs easily? Yes No

Follow simple age appropriate directions? Yes No

Toilet independently during the day? Yes No

Does your child:

Use crayons or markers to scribble or draw? Yes No

Listen to stories being read? Yes No

Recall stories or events? Yes No

Talk with your friends or relatives who come for a visit? Yes No

Have opportunity to play with other children? Yes No

Is there any other information regarding your child's development that you would like to share with us?

Signature of Parent/Guardian: _____ Date: _____