Wellsville Montessori Price List
202i-2022
(585)-593-5541

Per hour is based on 4 weeks at 7 hours a day or 4 weeks at 3 hours a day.

Days:	Cost per month:	Equivalent to:
5 Full Days	$546/month	$3.90/hour
5 Half Days	$376/month	$6.27/hour
4 Full Days	$482/month	$4.30/hour
4 Half Days	$343/month	$7.15/hour
3 Full Days	$403/month	$4.80/hour
3 Half Days	$290/month	$8.06/hour

(Begins September 2021)

*Registration Fee: $80.00 per student
*Daycare for Full Time Students: $4.00/hour
*Daycare for Part Time Students: $5.00/hour
*5% discount on tuition for second 4 or 5 full day student
No tuition payment over the summer to hold spot

Before & After School Daycare Price List
2021-2022

(Kindergarten & up, Begins September 2020)

Daycare	$5.00/hour
Registration Fee	$50.00 for 1 child $65.00 for 2 or more children

Wellsville Montessori School
125 School Street
Wellsville, NY 14895
(585) 593-5541
Preschool

Parent / School Contract

I am enrolling my child, _____, in the Wellsville Montessori School for the academic year _____, running from September through June.

I am enrolling my child for #_____ full / half days (please circle one).

I understand that the annual tuition rate is $5460.00 (5f) $3760.00 (5h) (please circle one).
$4820.00 (4f) $3430.00 (4h)
$4030.00 (3f) $2900.00 (3h)

This amount is payable in 10 monthly installments. Daycare rates are $4.00 per hour for full time students and $5.00 an hour for part time students. Parents of part time students must give at least 24-hour notice to the school when daycare hours are needed to ensure proper staffing. Day care hours are from 7:00 am - 9:00 am and 4:00 pm – 5:30 pm. There is a charge of $15.00 per hour for all children left at school after 5:30 pm.

I understand that this is an annual tuition and that I am responsible for its entirety. Since this is an annual charge, I will not be able to be refunded a portion of the tuition for the days missed due to my child's illness, vacation, withdrawal from the program or due to school closing for inclement weather. Withdrawal from school prior to the end of the month does not excuse tuition payment. Notice in writing must be submitted to the school Director at least 30 days prior to permanent withdrawal.

Tuition is due on the first of each month. If it is not paid by the tenth of the month a $20.00 late charge will be added to the balance. If the balance due is thirty days late, the child cannot attend school until the balance is paid or other arrangements have been made. Parents have the option to contact the Board of Directors and ask for an executive meeting to discuss their situation. If families are receiving assistance through DSS parents are required to pay whatever remaining balance is not paid by them.

There is a $20.00 returned check fee.

*All preschool children are accepted on a 60-day trial period. *

Daycare charges will be billed at the end of each month and can be paid with the next month's tuition. The same policy will be followed regarding late daycare payment as is followed regarding late tuition payments.

It is the responsibility of the parents to provide a lunch/snack daily for their child.

Children who have not yet been to Kindergarten will nap after lunch for approximately 45min. If children do not fall asleep, they will be allowed to get up and play quietly while others rest. WMS will provide mats and covers for the children to sleep on. Parents will provide a small blanket. Children will sleep on the floor in the classroom within the teachers view.

I agree to abide by the policies above

Parent signature (mother) Date

Parent Signature (father) Date

School Representative Signature Date

$80.00 (eighty dollars) registration and materials fee paid_____ Date _____ Cash / Check #

OCFS-LDSS-0792 (08/2019) FRONT

PHOTO OF CHILD (Optional)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PROGRAM NAME:	ADDRESS:	PHONE NUMBER:
WLSV Montessori School	125 School Street	(585) 593 - 5541

CHILD'S FULL NAME:
PREFERRED NAME/NICKNAME:
DATE OF BIRTH: / /
GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:

RELATIONSHIP TO CHILD:
☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____
☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD:
( ) - ☐ ok to text
EMAIL ADDRESS:

ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY
DATE OF ENROLLMENT: / /

FOR PROGRAM USE ONLY
DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:
DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

Wellsville Montessori School

Parental Release

My child / children _____ may be picked up from the Wellsville Montessori School by the following people:

Name (list parents also) Relationship Phone

_____

_____

_____

_____

_____

The following people are **not** allowed to pick up my child / children from school

_____

_____

Photo Release – Minors

As parent / guardian of _____

( ) I give my consent that photographs, videotapes and / or recordings of my child's voice may be used to promote Wellsville Montessori.

( ) I give my consent that photographs, videotapes and / or recordings of my child's voice may be used for classroom purposes only.

( ) I do not give my consent

Name: _____Relationship_____

Signature _____Date _____

Wellsville Montessori School
Health Insurance Information Form

Child's Name_____ DOB_____

Parents Name (please print)_____

The following Health Insurance information is required for enrollment into the Montessori School

NAME OF INSURANCE CARRIER_____

TYPE OF INSURANCE

ID#_____GROUP#_____

In the case of an accident or injury my child is covered by the above health insurance carrier and give my permission for this information to be released to health care officials in my absence.

OR

Medicaid Number_____ Sequence Number_____

Emergency Medical Permission

I hereby certify that I have authorized the Director or the Acting Director of the Wellsville Montessori School to obtain any emergency care for my child in the event that

01. it is in his/her opinion, a life threatening situation and
02. every reasonable effort has been made to obtain my permission first

Does your child have any medical conditions / allergies
_____Yes ___No.
If yes, please indicate condition and any instructions below. Remember we are not able to administer medication.

_____

_____

Parent Signature Date

Parent Signature Date

_____
Telephone

Home/Cell
_____Work_____

Signature of staff member accepting form Date Received

Wellsville Montessori School Registration Form

I would like to enroll my child for the _____school year.

Child's Full Name_____ birthday_____

Age & grade_____ WCS Teacher (if applicable)_____

Father's Name_____ Mother's Name_____

Address_____ Address_____

_____ _____

_____ _____

Phone # Home_____ Emergency #_____

Father's Work_____ Mother's Work#_____

Cell_____ Cell_____

E-mail_____ E-mail_____

I am registering my child for the

___ **WMS Preschool Program**

___ 5 Full Days (9:00 am - 4:00 pm)
___ 5 Mornings (9:00 am - 12:00 pm)
___ 4 Full Days (9:00 am - 4:00 pm) M T WTh F
___ 4 Mornings (9:00 am - 12:00 pm) M T W Th F
___ 3 Full Days (9:00 am- 4:00 pm) M T W Th F
___ 3 Mornings (9:00 am - 12:00 pm) M T W Th F
___ 7:00 - 9:00 am daycare hours needed
___ 4:00 pm - 5:30 pm daycare hours needed.

___**Before and After School Daycare Program**

	AM 7:00-9:00	PM 3:00-5:30
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

*****Please be a specific as possible with your arrival and pick up times*****

Preschool Note: September tuition is due by the 1st. If you have two children enrolled in the 5 full, 5 half, 4 full or 4 half day programs there is a 5% discount per additional child.

The following forms and non-refundable registration fee must be submitted before a child may attend:

Children Ages 3-5 years

__Physical form (signed by a Physician)
__Copy of Child's vaccination record
__Parent release/ Insurance/Medical release Form
__NYS Daycare Registration Form
__WMS Registration
__Parent /School Contract
__$80.00 Reg. Fee

Children Ages 5-12 years

__Parent release/ Insurance/Medical release Form
__NYS Daycare Registration Form
__WMS Registration
__Parent /School Contract
__$50.00 Reg. Fee (1 Child)
__$65.00 Reg. Fee (2 or more children)

RETURNING STUDENTS NEED TO BE REGISTERED BY May 17th TO KEEP YOUR SPOT.

Signature of Parent /Guardian

_____**Date**_____

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date