

Wellsville Montessori Price List 2021-2022 (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
B&A or Preschool Daycare

Parent / School Contract

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

My child will attend **M** _____ **T** _____ **W** _____ **TH** _____ **F** _____

There is a minimum charge of \$ 5.00 per day. There is a **\$50.00 registration fee per child, \$65.00 for 2 or more.** The daycare is due by the 10th of the following month and there is a late fee of \$20.00 after the 10th. If the balance due is thirty days late, the child cannot attend the program 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.

A ten day absentee rule is in effect for each child enrolled in the program. There will be a minimum charge per day for those missed beyond 10 days during the school year with no notification or other arrangements having been made. After 30 days the daycare spot will be forfeited. **Parents agree to contact the Wellsville Montessori School in the event of a child's absence.** There is a charge of \$15.00 per hour for all children left at school after 5:30 pm.

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

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

If your child will be here all day and has not yet been to Kindergarten they 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

Signatures of Parents or Guardians

Date _____

School Representative

_____ Date _____

registration and materials fee paid _____ (Date) _____ Cash / Check #

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	PROGRAM NAME: WLSV Montessori School		ADDRESS: 125 School Street		PHONE NUMBER: (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: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: () - <input type="checkbox"/> ok to text			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):		
EMAIL ADDRESS:					
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL	
	PRIMARY CONTACT:	<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text	
FOR PROGRAM USE ONLY			FOR PROGRAM USE ONLY		
DATE OF ENROLLMENT: / /			DATE OF DISENROLLMENT: / /		

CHILD'S FULL NAME:		DATE OF BIRTH: / /
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> 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.....		<input type="checkbox"/> Yes <input type="checkbox"/> 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.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /

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

Before and After School Daycare Program

<input type="checkbox"/> 5 Full Days (9:00 am - 4:00 pm)	AM 7:00-9:00	PM 3:00-5:30
<input type="checkbox"/> 5 Mornings (9:00 am - 12:00 pm)	Monday _____	_____
<input type="checkbox"/> 4 Full Days (9:00 am - 4:00 pm) M T WTh F	Tuesday _____	_____
<input type="checkbox"/> 4 Mornings (9:00 am - 12:00 pm) M T W Th F	Wednesday _____	_____
<input type="checkbox"/> 3 Full Days (9:00 am - 4:00 pm) M T W Th F	Thursday _____	_____
<input type="checkbox"/> 3 Mornings (9:00 am - 12:00 pm) M T W Th F	Friday _____	_____
<input type="checkbox"/> 7:00 - 9:00 am daycare hours needed		
<input type="checkbox"/> 4:00 pm - 5:30 pm daycare hours needed.		

*****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 _____

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

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

