Children's House – Early Childhood Program

Children's Kiva Montessori School

Enrollment Packet

2026-2027

BEST FORM OF CONTACT

Child's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Parent/Guardian's Name: _____

Address: _____ Address (if different): _____
(Street) (City, State) (Zip) (Street) (City, State) (Zip)

Cell/Home Phone: _____ Cell/Home Phone: _____

Work Phone:_____ Work Phone: _____

Email: _____ Email: _____

Please list all siblings that will be attending Children's Kiva Montessori Schools:

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Who is the BEST FORM OF CONTACT for Children's Kiva Montessori School to reach out to in the event of an emergency or other school needs and contact method: _____

Do you give permission to list your contact information in the all-school directory?
Yes _____ No_____

Do you want to receive election communication via email? (School meetings, updates, announcements, newsletters, etc.)
Yes _____ No_____

Does this student have an Individualized Education Plan (IEP)? Yes _____ No _____

What is the primary language spoken in the home? _____

Student's ethnicity: _____

CONTINUED ON NEXT PAGE…

BEST FORM OF CONTACT

Nondiscrimination Policy: Children's Kiva Montessori School shall comply with all applicable federal, state, and local laws, rules, and regulations, including, without limitation, the constitutional provisions prohibiting discrimination on the basis of disability, age, race, creed, color, gender, national origin, religion, ancestry, or sexual orientation. (Adopted by Children's Kiva Montessori School Board of Directors, March 10, 2014)

_____ _____

Parent/Guardian Signature Date

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EMERGENCY CONTACT INFORMATION

Date:_____

Child's Name: _____ Nickname:_____ Date of Birth:_____
(Last) (First)

Child resides with (circle one): Both Parents Mother Father Other:_____
(Please attach documentation regarding unique circumstances concerning guardianship of the above named child (i.e. Power of Attorney)

Parent/Guardian Name: _____ Cell Phone: _____
(Last) (First)

Home Address: _____ Home Phone: _____
(Street) (City, State) (Zip)

Employer/School: _____

Employer/School Address: _____ Phone: _____ Ext: _____
(Street) (City, State) (Zip)

Parent/Guardian Name: _____ Cell Phone: _____
(Last) (First)

Home Address: _____ Home Phone: _____
(If different) (Street) (City, State) (Zip)

Employer/School: _____

Employer/School Address: _____ Phone: _____ Ext: _____
(Street) (City, State) (Zip)

Emergency Contact: (Must be different from parents)

1. _____
(Name) (Relationship to Child) (Phone Number) (Cell Phone)

2. _____
(Name) (Relationship to Child) (Phone Number) (Cell Phone)

CONTINUED ON NEXT PAGE…

EMERGENCY CONTACT INFORMATION

Additional Persons Authorized to PICK UP CHILD: Your child will ONLY be released to individuals listed below; a valid form of identification must be shown to staff prior to your child's release.

1. _____
   (Name) (Relationship to Child) (Phone Number) (Cell Phone)

2. _____
   (Name) (Relationship to Child) (Phone Number) (Cell Phone)

3. _____
   (Name) (Relationship to Child) (Phone Number) (Cell Phone)

Are there **any restrictions** on who may pick up your child? If yes, please explain and provide documentation if applicable.

AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND TRANSPORTATION

In the event of an emergency, I hereby give my permission for the school staff to access emergency medical services for my child, including transport to the nearest health care facility to receive emergency medical or surgical care and treatment.

It is understood that a conscientious effort will be made to locate me. I accept the expense of care and transport.

Child's Full Name: _____ Date of Birth: _____

Child's Weight: _____ Child's Gender: _____

Date of Last Tetanus Vaccination: _____

Health Insurance Provider: _____

Member ID / No. _____

Primary Care Provider: _____

Primary Care Contact Information:

Address:_____

Phone Number: _____

Allergies/Reactions: _____

_____

Chronic Illnesses/Special Needs: _____

_____

Medications: _____

_____

_____ _____

Parent/Guardian Signature Date

AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND TRANSPORTATION

For Staff Use Only:

Staff Use: Current Photo of Child

GENERAL HEALTH APPRAISAL FORM

The Kiva must obtain for every preschool child who enrolls a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled child care program**.**

This report is to be filled out by a licensed physician or other health professional that has seen the child annually to comply with State Standards.

Parent: Please complete and sign:

Child's Name_____ Sex _____ Date of Birth_____

Allergies: None or Describe _____

Type of Reaction_____

Dietary Restrictions_____

I, _____ give consent for my child's health care provider, school personnel to discuss my child's health care concerns. My child's health care provider may fax this form (and applicable attachments) to my child's school. Fax #: 970-565-3004

Parent/Guardian Signature _____Date: _____

HEALTH CARE PROVIDER: Please complete this portion after Parent Section has been completed.

Date of previous Health Appraisal: _____ Date of Today's Exam: _____ Weight at Exam:_____

Physical Examination: ☐Normal ☐Abnormal (specify): _____

Significant Health Concerns: ___Severe Allergies ___Reactive Airway Disease ___Asthma ___Seizures ___Diabetes ___Developmental Delays ___Behavior Concerns ___Vision ___Hearing ___Dental ___Nutritional ___Other:_____

Explain above concerns (if necessary, include instructions to care providers): _____

_____

Describe and physical condition requiring the facility's special attention: _____

_____

Medication(s) prescribed: _____

Note: Separate medication authorization form is required for medications given at school, childcare, or camp.

CONTINUED ON NEXT PAGE…

GENERAL HEALTH APPRAISAL FORM

Allergies:_____ and prescribed routine: _____

Dietary Restrictions: _____ and prescribed routine: _____

Screenings performed: ___Vision (Normal/Abnormal) ___Hearing (Normal/Abnormal) ___Dental (Normal/Abnormal)

Please record immunizations and dates administered on the Colorado Department of Health Certificate of immunization and attach to this form.

This child is healthy and may participate in all routine activities in school sports, child care or camp programs. Any concerns or exceptions are identified on this form.

_____ _____

Signature of licensed physician or other health care professional Date

Please Print or Stamp:

_____

Printed Name of Physician/Health Care Professional

_____

Address City State

_____

Zip Code

GENERAL HEALTH APPRAISAL FORM (District Use)

Student's Legal Name: _____ Male/Female Date of Birth: _____

Parent(s)/Guardian(s): _____ Phone Number(s): _____

Physician's Name: _____ Physician's Phone Number: _____

Approximate date of last medical visit: _____

If you would like information about finding a Primary Care Provider and/or Health Insurance, please check here ☐

IF YOUR STUDENT DOES NOT HAVE ANY MEDICAL CONDITIONS OR TAKE MEDICATION
INITIAL HERE _____
AND COMPLETE THE REST OF THIS FORM

Medical History/Conditions: List any serious illnesses, accidents, hospitalization or surgery (include age):

_____

_____

_____

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GENERAL HEALTH APPRAISAL FORM (District Use)

Condition	Y/N circle one	Condition	Y/N circle one
Asthma?	Yes No	Neurological Concerns?	Yes No
Last Attack _____		Seizures? Type _____	Yes No
Inhaler at home?	Yes No	Last known seizure_____	
Inhaler at school?	Yes No	Medication(s)_____	
Attention Deficit Disorder (ADD)	Yes No	Skin Conditions?_____	Yes No
ADHD/ADD medication at school?	Yes No	Location? _____	Yes No
Medication(s)_____	Yes No	Frequent Nosebleeds?	Yes No
Diabetes (Type)_____	Yes No	Bone or Muscle problems? _____	Yes No
Blood Glucose check at school?	Yes No	Dental pain or decay? _____	Yes No
Medication(s) at school?	Yes No	Stomach problems? _____	Yes No
Medication(s)_____	Yes No		
Headaches (fewer than 2 per week)	Yes No	Bladder problems? _____ _____	Yes No
Migraines diagnosed by MD?	Yes No		
Medication(s) at school? _____	Yes No		
Emotional/Behavioral Issues? _____	Yes No	Other Health Issues not listed? (e.g blood discorder, cancer, respiratory disease, etc.) Explain: _____ _____ _____	Yes No
Medication(s) at school?	Yes No		
Medication(s):_____ _____	Yes No		
Head Injury?_____	Yes No	ALLERGIES: List type of allergy (food, insect, medication), type of reaction (rash, trouble breathing, tongue swelling), and medication that will be used at school for severe allergic reactions 1. _____ _____ 2. _____ _____ 3. _____ _____	
Loss of consciousness?_____	Yes No		
Concussion? _____	Yes No		
Behavior change after injury? _____	Yes No		
Hearing Concerns? _____	Yes No		
Vision Concerns?_____	Yes No		
Wears glasses or contacts lenses at school? (circle one)	Yes No		
Date of last eye exam: _____			

CONTINUED ON NEXT PAGE…

GENERAL HEALTH APPRAISAL FORM (District Use)

_____ _____

Parent/Guardian Signature Date

BEST Daytime Contact Number(s): _____

In case of emergency and I am NOT available, please contact:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

PHOTO / VIDEO RELEASE

I hereby consent to have my child, _____, be photographed and / or videoed by Children's Kiva Montessori School, Inc. and/or make use of my child's name for the following purposes:

(INITIAL ALL THAT APPLY:

_____ Newspaper articles or related marketing such as advertisements, brochures, flyers, etc.
_____ On-line Media including the school website and Facebook. (Children are NOT tagged);
_____ In-house classroom newsletters, reports or bulletin boards.

PLEASE NOTE: Children's House cannot be held responsible for images captured in public locations and posted by members of the media or non-employees.

_____ _____
Parent/Guardian Signature Date

ALL SCHOOL DIRECTORY

The Children's Kiva makes available to families as a resource an all-school directory of students and staff, listed alphabetically, with the following information:

Child's Name Address Phone Number Parents Name

Do you give permission to use your name and phone number? Yes _____ No _____

Student's Name _____

_____ _____
Parent/Guardian Signature Date

CONTINUED ON NEXT PAGE…

ON-LINE OPT OUT

All correspondence including but not limited to newsletters, tuition statements & announcements to families will come in an online format via email. Parents, who prefer to have PAPER COPIES placed in your parent folder, please indicate below.

I, _____ prefer to have PAPER COPIES of all Children's House related

correspondence placed in my parent folder, located in my child's classroom.

_____ _____

Parent/Guardian Signature Date

PARENT/STUDENT HANDBOOK SIGNATURE PAGE

2025-2026 Student & Parent Handbook Acknowledgement

By my signature below, I confirm that I have reviewed or will review the Children's Kiva Montessori School ***Student and Parent Handbook***, ***2025-2026*** I affirm my understanding of all parent and student expectations, including all policies and procedures as outlined therein, and hereby agree to abide by them.

I further commit to the philosophy of open and respectful communication between home and school as well as active participation in order to enhance the learning of all students enrolled at the Children's Kiva Montessori School. To that end, I will endeavor to become an involved parent (working collaboratively with my child's teacher and supporting school sponsored activities) and in so doing build a school of excellence for all.

I also agree that I have read or will read and will comply with the rights, responsibilities, policies, and procedures as outlined in the Children's Kiva Montessori School Parent Code of Conduct and Communication Guidelines published in the Student & Parent Handbook and the Children's Kiva Conflict Resolution Policy as outlined in the Board of Directors Policies Manual.

_____ _____

Printed Name Date

_____

Parent/Guardian Signature

PARENT/TEACHER ORGANIZATION (PTO)

Welcome! All parents and guardians of students, plus all staff of Children's House and Elementary/Middle School are automatically granted PTO membership. There are no membership dues. The PTO serves as a liaison between parents, teachers, staff, and the Board of Directors with the goal of enriching the school community. We strive to create a welcoming and inclusive atmosphere for families to engage more deeply in their student's education by providing a forum for sharing ideas and by sponsoring opportunities for family involvement.

What Does the PTO Do?

- Meet once a month, for one hour, to provide a forum for parents to voice concerns and ideas
- Coordinate and communicate parent volunteer opportunities
- Sponsor fundraisers in order to provide financial support for needs identified by teachers, staff and parents
- Coordinate mentor program for parents new to the Montessori curriculum
- Support school outreach events, parent education nights or other programs as identified by the Head of School (HOS) and Children's House Director (CHD)
- And much, much more

The PTO Needs You

The PTO needs new leadership in order to continue. All officer positions are open, including President, Vice-President, Volunteer Director, Treasurer and Secretary. Current officers are happy to help with your transition to these roles. **Please request the PTO Membership form and let us know about your interests.**

Strong parent involvement is a proven way to increase your student's educational, emotional and lifelong success. Again, we look forward to an exciting school year and the PTO is excited to continue to grow and serve the Children's House and the Elementary / Middle School.

Please contact the PTO with any questions at kelly.glenn@childrenskiva.org