The Lab School
APPLICATION FOR ADMISSION

514 E. Argonne Drive, Kirkwood, MO 63122
www.thelabschool.com 314-822-8282 Enrollment for Fall 20______

CHILD'S NAME________________________________Preferred Name__________Gender___DOB_______

ADDRESS (Street/City)____ZIP_______

HALF-DAY SCHOOL - 9:00 - 11:45

____ T/TH 3's ____ MWF 3's ____ M thru F 3's ____ M thru F young 4's ____ M thru F older 4's & 5's

LUNCH BUNCH - includes catered meal 11:45 - 1:45 (circle days you need) M T W TH F

EARLY CARE – 7:00 A.M. – 9:00 A.M. (circle days you need) M T W TH F

EXTENDED SCHOOL – 11:45 – 6:00 (circle days you need) M T W TH F

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PARENT'S NAME________________________________Home Phone(____)________________

E-MAIL ADDRESS________________________________Cell Phone________________

ADDRESS (Street, City, State, Zip Code)____

EMPLOYED BY________________________________HOURS: From ______ to ______

EMPLOYER'S ADDRESS________________________________BUSINESS PHONE____________

PARENT'S NAME________________________________Home Phone(____)________________

E-MAIL ADDRESS________________________________Cell Phone________________

ADDRESS (Street, City, State, Zip Code)____

EMPLOYED BY________________________________HOURS: From ______ to ______

EMPLOYER'S ADDRESS________________________________BUSINESS PHONE____________

BROTHERS/SISTERS (Names, Ages)____

PERSON(S) AUTHORIZED TO PICK UP MY CHILD – include parent(s)

Name____________________Cell__________ Name____________________Cell__________

Name____________________Cell__________ Name____________________Cell__________

OVER – IMPORTANT EMERGENCY INFORMATION TO COMPLETE

AUTHORIZATION FOR EMERGENCY/MEDICAL CARE   CHILD'S NAME__________________

I understand I will be notified in case of accident/illness, and I will make arrangements for medical care. If I cannot be reached or, in a critical emergency requiring medical care, I hereby grant permission for the staff of The Lab School to take whatever steps may be necessary to obtain emergency medical care.

LOCAL EMERGENCY CONTACTS OTHER THAN PARENT(S) OR DOCTOR

(Name,Cell/Home Phone, Relationship)

1.____

2.____

CONTACTING PEDIATRICIAN/CLINIC Doctor____________________Phone____________

Exchange____________Address______________________________________

HOSPITAL PREFERENCE Name of Hospital_______________________Phone__________

Address____

ALLERGIES/MEDICAL CONDITIONS/SPECIAL MEDICATIONS/SPECIAL NEEDS, BEHAVIORS:

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FIELD TRIPS Our child has permission to go on walking field trips with The Lab School staff. I understand that I will be notified when such trips are planned. I understand that there will be a minimum of two staff members on each trip.

AGREEMENTS The provider and I have agreed on:

-A communication plan regarding my child (scheduled conferences, class newsletters, school newsletters, year-end reports).
-Required health and safety inspections are available for review in the office.
-When my child is ill, I understand that he/she will not attend school.
-Policies regarding admission, care and release of children will be provided in a parent handbook before school starts.
-A copy of the Licensing Rules for Centers in Missouri is available in the office for review.

PARENT(S)/LEGAL GUARDIAN SIGNATURE (This certifies that my child is, to my knowledge, in good health and free of disabilities that would endanger him/her or other children in the school. I agree to everything noted above).

___________________________________ Date________________

___________________________________ Date________________

OFFICE USE ONLY:

Admission Date____________Days of Week Enrolled______________

Hours: Enrolled from______________to____________________