MOUNT LEBANON
Montessori
SCHOOL AND ACADEMY

Please verify the information below. Then return to the office with your first tuition payment.

School Directory DOB: ___/___/20____
Student's Name: _____ *
Parents Names: _____ *
Address: _____ *
City, State Zip: _____, PA _____ *
Directory Number: _____-_____-_____ *
I give permission to share the * information in the school directory ___ (initial for consent)

School Messenger
Communication to parents and non-school hours notifications
(weather delays, reminders, school mail, and emails from teachers etc.)

Contact 1 - Phone: _____-_____-_____ Email:

Contact 2 - Phone:_____-_____-_____ Email:

Emergency Contacts and Pick Up
In the event of illness or injury school personnel will attempt to contact you
in the order you indicate below. Please list at least two LOCAL RESIDENTS
who have consent to be able to transport and care for your child.

Name / Phone / Relationship / has permission to pick up from school
1st - Parent_____ Yes

2nd - _____ Yes

3rd - _____ Yes/No

4th - _____ Yes/No

5th - _____ Yes/No

Medical Condition / Allergies

Medication / Treatment (Medication Release Form MUST be current & on file in the office)

Child's Physician _____ Phone_____
If this child has any special health problems please list above.
Signatures _____Date_____