

2010-2011 STUDENT APPLICATION

Lake Mary Montessori Academy, Inc.

3551 W. Lake Mary Blvd., Lake Mary, FL 32746

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Heads of School: Sheila Linville M.A.T. & Scott Linville M.A.

Please check one

Half Day Pre-school Program: (8:30 – 12:30) _____ or with Elementary Sibling _____ (8:00-12:30)

Full Day Pre-school & Kindergarten: (8:30-2:30) _____ or with Elementary Sibling _____ (8:00-2:45)

Elementary: (8:00 – 2:45) _____

*The Transition Program will be 8:30-10:30 a.m. for the first two weeks of school for new children ages 3 & 4

Date: _____

STUDENT PROFILE: Please print clearly.

Applicant's Name(s) _____
(Last) (First) (Middle) (Preferred)

(Last) (First) (Middle) (Preferred)

(Last) (First) (Middle) (Preferred)

Home Address _____
(Street) (City) (State) (Zip Code)

Neighborhood _____ Male _____ Female _____ Birth Date _____

FAMILY INFORMATION: Please print clearly.

Marital Status of Parents: [] Single [] Married [] Separated [] Divorced [] Widowed

Mother Name (Dr./Mrs./Ms.) _____

Father Name (Dr./Mr.) _____

Home Address _____
If different from applicant's

Home Address _____
If different from applicant's

Home Phone _____

Home Phone _____

Cell Phone _____

Cell Phone _____

E-Mail _____

E-Mail _____

Work Phone _____

Work Phone _____

Occupation _____

Occupation _____

Company Name _____

Company Name _____

Driver's License _____

Driver's License _____

Social Security Number _____

Social Security Number _____

FAMILY PROFILE

With whom does the child live? _____ Name of Step Parent _____

Who is financially responsible for the child? _____

Applicant's siblings

Name *Age* *Birth Date* *School Attending*

COMMUNITY INVOLVEMENT

Please note what organizations you are personally affiliated with or active in:

TRANSITION PROGRAM

New Primary children will transition with 2 weeks of a schedule from 8:30-10:30 a.m. This enables younger children to have a shorter day and make the adjustment to school a happy and successful experience for both parent and child.

OFFICE INFORMATION

Child's Physician's Name/Address: _____

Physician's Phone: _____

Person(s) to pick up your child and in case of illness or emergency, if parents cannot be contacted:

1. _____
(Name) (Phone) (Relationship)

2. _____
(Name) (Phone) (Relationship)

GRANDPARENTS

Maternal:

Paternal:

Title First Name(s) Last Name(s)

Title First Name(s) Last Name(s)

Street

Street

City State Zip Code

City State Zip Code

E-Mail

E-Mail

SIGNATURES

Father's Signature *Date*

Mother's Signature *Date*

At the family visit, there is a \$75.00 Assessment and Application fee. The Heads of School will talk with your family about your child's acceptance. The Enrollment Deposit of \$300 will be due to reserve your child's space for the upcoming academic year. All fees are non-refundable.