

# APPLICATION FORM

Complete all parts of this form and submit it to:

academicdirector@bbmschool.ca

## STUDENT INFORMATION

### Student 1

Last Name	First Name	Middle Name	Preferred Common Name
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Date of Birth (YYYY/MM/DD)	Place of Birth (City/Country)	BC Personal Health (Care Card) #
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Gender	Residential Status	Personal Education Number (PEN)
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Study Permit	

Program:	Preferred Start Date
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<b>NIDO (0-3)</b> <i>Nest</i>	<b>CASA (3-6)</b> <i>Children's house</i>		<b>ELEMENTARY (6-12)</b>	
<input type="checkbox"/> <b>Nido 0-3 years</b>	<input type="checkbox"/> <b>Casa 3-4 years</b>	<input type="checkbox"/> <b>Kindergarten 5 years</b>	<input type="checkbox"/> <b>Lower Elementary 6-9 years</b>	<input type="checkbox"/> <b>Upper Elementary 9-12 years</b>
7:30am-5:30pm (12 months)	<input type="checkbox"/> Morning program 8:30am-11:30am (Sept – June)	8:30am-3:00pm (Sept – June)	8:30am-3:00pm (Sept – June)	8:30am-3:00pm (Sept – June)
<input type="checkbox"/> 2 days / week	<input type="checkbox"/> Extended day 8:30am-3:00pm (Sept – June)		Year:	Year:
<input type="checkbox"/> 3 days / week	<input type="checkbox"/> Full-time 7:30am-5:30pm (12 months)			
<input type="checkbox"/> 5 days / week				

## Student 2

Last Name	First Name	Middle Name	Preferred Common Name
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Date of Birth (YYYY/MM/DD)	Place of Birth (City/Country)	BC Personal Health (Care Card) #
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Gender	Residential Status	Personal Education Number (PEN)
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Study Permit	

Program:	Preferred Start Date
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<b>NIDO (0-3)</b> <i>Nest</i>	<b>CASA (3-6)</b> <i>Children's house</i>		<b>ELEMENTARY (6-12)</b>	
<input type="checkbox"/> <b>Nido 0-3 years</b>	<input type="checkbox"/> <b>Casa 3-4 years</b>	<input type="checkbox"/> <b>Kindergarten 5 years</b>	<input type="checkbox"/> <b>Lower Elementary 6-9 years</b>	<input type="checkbox"/> <b>Upper Elementary 9-12 years</b>
7:30am-5:30pm (12 months)	<input type="checkbox"/> Morning program 8:30am-11:30am (Sept – June)	8:30am-3:00pm (Sept – June)	8:30am-3:00pm (Sept – June)	8:30am-3:00pm (Sept – June)
<input type="checkbox"/> 2 days / week	<input type="checkbox"/> Extended day 8:30am-3:00pm (Sept – June)		Year:	Year:
<input type="checkbox"/> 3 days / week	<input type="checkbox"/> Full-time 7:30am-5:30pm (12 months)			
<input type="checkbox"/> 5 days / week				

## HOUSEHOLD INFORMATION

### Parent 1

Name (First/Last)		Email Address	
Street Address		City	Province Home Phone #
Occupation	Employer	Cell Phone #	Work Phone #
Residential Status			
<input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Work Permit			

### Parent 2

Name (First/Last)		Email Address	
Street Address		City	Province Home Phone #
Occupation	Employer	Cell Phone #	Work Phone #
Residential Status			
<input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Work Permit			

Do you have other children under 5 years old? (Name/Birthdate)	
Do you have other children in Grades K-12 enrolled elsewhere?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## SUPPORT

Please indicate if your child has received support in any of the following areas:

**Child's Name:**

- |  |  |                         |
|--|--|-------------------------|
| Learning Assistance or Special Education | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |
| English Language Learner                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |
| Speech / Language Assessment or Therapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |
| Psycho-Educational Assessment            | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |
| Gifted Education / Learning Enrichment   | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |
| Occupational Therapy                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |
| IEP / other Education Support Plan       | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, years Received: |

## DISCLOSURE:

Complete and full disclosure of all information about your child's learning strengths and weaknesses is essential for the school to ensure that the applicant can be properly accommodated. Failure to disclose pertinent information may result in the repealing of the applicant's admission or enrollment status at any time. This caveat is a means to protect the integrity of the teaching environment for both the current student community and for the student applicant. Failure to disclose information may result in situations where Boundary Bay Montessori is unable to properly plan for and provide adequate resources or staffing.

Pertinent information includes but is not limited to: resource needs, professional clinical or health assessments, medical health issues, behavioral challenges and past or present circumstances that, may directly impact the overall well-being of the applicant, our staff and the current student body.

## AFFIRMATION:

*The information provided in and attached to this application is accurate to the best of my/our knowledge. By signing below I/we confirm my/our understanding of the above and attest to honest disclosure in this application.*

Parent/Guardian: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_