



Lefferts Gardens Montessori

Elementary

Re-Enrollment Packet

School Year

2015 - 2016

www.mylgm.com
527 Rogers Avenue, Brooklyn, NY 11225
(718) 773-0287



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Elementary Re-Enrollment Checklist

Please return the following by **March 15, 2015**:

- Child Information, Child Photo, and Emergency Contact Form
- Blue Student Emergency Card (*Front and Back must be filled out*)
- Parent(s)/Guardian(s) Information (*2 pages*)
- Financial Responsibility *Please initial this page*
- Elementary Annual Tuition *Please make your selection*
- Automatic Withdrawal via Tuition Express (*optional*)
- Activities and Medical Care and Photo Permission Form (*2 pages*)
- Pick-up Release Authorization *Must be accompanied with a photograph(s)*
- Special Notes for Parents
- New Admissions Examination Form *Must be submitted before admission. Children may not attend school without this medical form.*
- Partial Re-Enrollment Fee, to ensure a space at LGME. Checks payable to: LGM



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*Paste photo of your child here.

Re-Admissions Information*

Date: _____

Child's Information

First Name: _____ Last Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Birth date: _____ Check one: Male Female

Lives with: Both parents Mother Father Other _____

*Please include a recent photo of your child.

EMERGENCY CONTACT INFORMATION (other than parents/guardians)

Contact 1

First Name: _____ Last Name: _____

Relationship: _____ Other _____

Home: (____) ____ - ____ Cell: (____) ____ - ____

Work: (____) ____ - ____ Other: (____) ____ - ____

Contact 2

First Name: _____ Last Name: _____

Relationship: _____ Other _____

Home: (____) ____ - ____ Cell: (____) ____ - ____

Work: (____) ____ - ____ Other: (____) ____ - ____

*Lefferts Gardens Montessori School welcomes students of any race, color, religion, national or ethnic origin.

For Office Use Only

- Verify Soc Sec #
- Photocopy photo ID
- Cellphone(s) #



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Re-Admissions Information (cont'd)

Date: _____

Parent/Guardian Information

Relationship: Mother Father Guardian Other: _____

First Name: _____ Last Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Education: _____ Social Security #: _____

Social Security numbers are requested for the collection of any outstanding debts to LGM. All information is confidential. You will be asked to furnish this information as a final step in the re-enrollment process.

Status: Married Single Separated Divorced. .

Home: (____) ____ - ____ ____ Cell: (____) ____ - ____ ____

Work: (____) ____ - ____ ____ Other: (____) ____ - ____ ____

Email: _____

Cell Phone Carrier:

(in case of an emergency or school closure, we can notify you via text message in addition to contacting you via phone)

Occupation: _____

Employer: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Interests/Activities: _____

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- Verify Soc Sec #
- Photocopy photo ID
- Cellphone(s) #



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Re-Admissions Information (cont'd)

Date: _____

Parent/Guardian Information

Relationship: Mother Father Guardian Other: _____

First Name: _____ Last Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Education: _____ Social Security #: _____

Social Security numbers are requested for the collection of any outstanding debts to LGM. All information is confidential. You will be asked to furnish this information as a final step in the re-enrollment process.

Status: Married Single Separated Divorced. .

Home: (____) ____ - ____ ____ Cell: (____) ____ - ____ ____

Work: (____) ____ - ____ ____ Other: (____) ____ - ____ ____

Email: _____

Cell Phone Carrier:

(in case of an emergency or school closure, we can notify you via text message in addition to contacting you via phone)

Occupation: _____

Employer: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Interests/Activities: _____

For Office Use Only

- Verify Soc Sec #
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- Cellphone(s) #



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Financial Responsibility

The Parent(s)/Guardian(s) hereby agree(s) to pay full tuition and fees for the school year. These payments are not subject to reduction, adjustment, or refund due to illness, absence, or withdrawal of the student from the School unless the withdrawal is made at the request of the School. The School reserves the right to request withdrawal of a student and in such a case will prorate the tuition on a per diem basis in accordance with the School's calendar year, except where withdrawal is requested by reason of non-payment of tuition.

Tuition Payment Policy

We prefer parents pay the full tuition by September 5th. Payment on an installment basis is also accepted. Semi-annual payments are due by September 5th and January 5th. Monthly payments are due by the 5th of each month. We offer a 1% reduction of tuition for parents who sign-up for **Automatic Withdrawal** on a monthly basis over the school year.

Failure to Pay

If failure to pay an installment extends beyond thirty (30) days, the School reserves the right to demand full payment of the remaining balance of tuition plus any accrued finance charges. Any balance due and payable, whether an installment or otherwise, which remains outstanding after the fifth (5th) day of the month shall be subject to a finance charge of 1.5% per month. The calculation of this finance charge shall be compounded monthly on all outstanding arrears including the finance charge. In the events of a default in the payment of tuition or other charges, the Parent/Guardian shall be responsible for the expenses incurred by the School for collection including but not limited to collection of expenses, filing costs, and reasonable attorney fees.

Dishonored Checks

A charge of \$60 per occurrence of a dishonored check shall be due and payable to cover bank charges and administrative expenses.

Late Pickup Fee

Any child with a 3:30p.m pick-up who is not picked up by 3:30p.m will join the Artz N More after-school program and will be billed by Artz N More @ \$1.00 per minute after 3:30p.m.

Initial Here _____



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Below is the tuition table for the 2015-2016 school year. Please check off the schedule that is applicable to you. Your annual total will automatically be added up for you. A 5% sibling discount is available for families enrolling more than one child at Lefferts Gardens Montessori during the same school year.

ELEMENTARY ANNUAL TUITION **\$15,000**

Payment Options:

- One Payment (3% discount) \$14,550
- Two Payments (Sept 15 & Jan 15) 2% discount \$ 7,350 x 2
- Ten Payments (First of Each Month) \$ 1,500 x 10
- Materials/Supplies Fee \$ 150
- Pizza Wednesday (October 2015 through June 2016) \$ 120 (*optional*)

Elementary Program:

Time: 08:30 A.M - 3:30 P.M. Monday – Friday

A partial non-refundable Re-Enrollment Fee of **\$550 dollars is due by April 15, 2015** with this contract. The balance of **(\$750)** will be due no later than **June 15, 2016**. This **non-refundable \$1,500 payment** represents the first month's payment of the annual tuition.

I have read and understand Lefferts Gardens Montessori Re-Enrollment Contract Agreement. I agree to abide and support the policies as specified.

Signature _____ Signature _____

Print _____ Print _____

Date: ___ / ___ / _____

Date ___ / ___ / _____

***Tuition, fees, and charges are subject to change by administrative, legislative, or regent action, and changes become effective on the date enacted.*



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Automatic Withdrawal via Tuition Express

<input type="checkbox"/> Bank Type of account: _____ Checking _____ Savings Bank name: _____ Routing # (9 digits): _____ Account #: _____ If withdrawal is from your checking account, please submit a copy of a VOIDED check.	<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Debit card Name on card: _____ Card #: _____ Expiration date: ____ / ____ Date: _____ CVV #: _____ Authorization signature: _____
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For a 1% discount on my annual payment, I agree to have the monthly payment of \$ _____ automatically withdrawn on the 1st of each month beginning September 1, 2015 and ending on June 1, 2016.

Pizza Wednesday has become a much loved tradition at Lefferts Gardens Montessori. It gives parents a much needed break from packing lunch each day. **Pizza Wednesday is optional for \$120/school year.** Each week, LGM arranges for pizza for each participating child. If you choose to opt out of Pizza Wednesday, please pack your child's lunch accordingly.

OPT OUT: My child **will not** participate in Pizza Wednesday for the 2015-2016 school year. I understand that I must send him/her with lunch on Wednesdays and will be billed if my child participates but has not enrolled in the program.

Signature _____ Signature _____

Print _____ Print _____

Date: ____ / ____ / ____

Date ____ / ____ / ____



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Activities and Medical Care Permission Form

I hereby grant permission for my child/children to use all of the play equipment and participate in all of the activities of the school.

I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks or for field trips in an authorized vehicle.

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include but are not limited to the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact the child's physician.
3. Attempts to contact any of the persons you listed in the **Emergency Contact Information** section and Emergency cards.

If we cannot contact you or your child's physician, we will do any or all of the following with all expenses incurred being borne by the child's family:

1. Call our school's physician or paramedics.
2. Call an ambulance.
3. Have a staff member accompany the child to the nearest hospital emergency ward.

In compliance with State regulations, a parent or guardian must sign this blanket release authorization giving a) an emergency room, b) first aid squad, or c) a physician permission to provide emergency medical treatment in case you or your authorized emergency contact person (see page 2) cannot be reached.

Signature

Signature

Print name

Print name

Date: ___/___/_____

Date: ___/___/_____



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Photo Permission Form

I hereby grant(s) Lefferts Gardens Montessori permission for the use of pictures in which my child appears for school promotional, public relations, and educational purposes. Any photographs taken of any student shall remain the exclusive property of the school.

Signature

Signature

Print name

Print name

Date: __/__/____

Date: __/__/____



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Pick-up Release Authorization

The following person(s) is/are authorized to pick-up my child/children:

Name	Relationship	Phone Type	Phone Number	Phone Type	Phone Number

I understand that my child/children will not be released to any adult other than those listed above without advanced written parental permission. I will provide a photograph of each individual authorized to pick up my child. (Pictures can be sent via e-mail to admin@mylgm.com). Otherwise, I will inform the authorized individual to present a state I.D. to an LGM staff member, which they can photocopy for my child/children's records.

Signature

Print name

Date: ___/___/_____

Signature

Print name

Date: ___/___/_____

NEW ADMISSION EXAMINATION FORM

DEPT. OF HEALTH & MENTAL HYGIENE — DEPT. OF EDUCATION
Return in 2 Weeks. Please Print Clearly / Press Hard

HEALTH MESSAGE

STUDENT ID # / OSIS

See Reverse Side

TO BE COMPLETED BY THE PARENT OR GUARDIAN

STUDENT LAST NAME		FIRST NAME		MIDDLE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDAY MONTH DAY YEAR		RACE/ETHNICITY <i>Check all that apply</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> White <input type="checkbox"/> Other	
<input type="checkbox"/> PARENT	LAST NAME	FIRST NAME	STUDENT ADDRESS			APT/FL	TELEPHONE NO. HOME: ()		
<input type="checkbox"/> GUARDIAN						ZIP	WORK: ()		
<input type="checkbox"/> FOSTER PARENT									
SCHOOL	DISTRICT	NUMBER	<input type="checkbox"/> Public Elem <input type="checkbox"/> Public H.S. <input type="checkbox"/> Public JHS/IS <input type="checkbox"/> Non-Public		SCHOOL NAME:	<input type="checkbox"/> Annex 1 <input type="checkbox"/> Annex 2	Does this child have any form of health insurance, including Medicaid or Child Health Plus?		<input type="checkbox"/> Yes <input type="checkbox"/> No

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

If yes to any item, provide:

Does the student have a past or present medical history of the following:

PRES.	PAST	NO	Item	PRES.	PAST	NO	Item	DATE	DETAILS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA (If present, attach medication administration form)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (If present attach medication administration form)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Accidents		
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Problems/Limitations		

PHYSICAL EXAMINATION: HEIGHT _____ in (%/o ile) WEIGHT _____ lb (%/o ile) BMI _____ (%/o ile) BLOOD PRESSURE _____ / _____

GENERAL APPEARANCE (NUTRITIONAL STATUS): _____

NL	AB	HEENT	NL	AB	LYMPH NODES	NL	AB	ABDOMEN	NL	AB	BACK	NL	AB	GROSS MOTOR
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	DENTAL STATUS	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	GENITO URINARY	<input type="checkbox"/>	<input type="checkbox"/>	SKIN	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHO/SOCIAL DEV.
<input type="checkbox"/>	<input type="checkbox"/>	NECK	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	NEURO	<input type="checkbox"/>	<input type="checkbox"/>	LANGUAGE
												<input type="checkbox"/>	<input type="checkbox"/>	BEHAVIORAL
												<input type="checkbox"/>	<input type="checkbox"/>	FINE MOTOR

DESCRIBE ABNORMALITIES: _____

Hearing	DATE	RESULTS	Vision	FAR	NEAR	FUSION	P	F	<i>Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test.</i>
AUDIO/SWEEP	_____	P F	Right	____/____	____/____				
THRESHOLD	_____	P F	Left	____/____	____/____	COLOR	P	F	
			Both	____/____	____/____				

TB: Only required for students newly entering the NYC school system in Intermediate/Middle/Junior or High School

MANTOUX	DATE	RESULTS	BLOOD-BASED TB TEST	RESULTS	Chest X-ray	BCG	On INH
(PPD) IMPLANTED	_____	<input type="checkbox"/> NEGATIVE _____ MM	Name	<input type="checkbox"/> POS	DATE	____/____/____	____/____/____
READ	_____	<input type="checkbox"/> POSITIVE _____ MM	Date	<input type="checkbox"/> NEG	RESULTS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not Indicated	<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO

LEAD: Risk Assessment DATE DONE _____ RESULTS No Risk At Risk If at risk, do venous lead screening DATE DONE _____ RESULTS _____

IMMUNIZATION — DATES Citywide Immunization Registry no. _____

DPT/DaP or DT or Td	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Other	____/____/____
IPV/OPV	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____		
Hepatitis B	____/____/____	____/____/____	____/____/____	MMR	____/____/____		
HIB	____/____/____	____/____/____	____/____/____	VZV	____/____/____		

May provide copy of CIR print out in lieu of completing this section. Must complete CIR Number above.

DIAGNOSES — If Asthma, indicate severity

Well Child V202 ICD CODE _____

DATE OF EXAM: _____	DOH ONLY	PROVIDER I.D. _____
Physician Signature	TYPE OF EXAMINATION: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year/s	
Physician Name (Print)	Comments	
Address	_____	
Telephone	Date Reviewed: _____	
Name of facility	REVIEWER: _____	
Type of facility	I.D. NUMBER _____	
<input type="checkbox"/> HHC Child Health Clinic <input type="checkbox"/> Private Practice <input type="checkbox"/> School-Based Clinic		
<input type="checkbox"/> HHC Communicare Clinic <input type="checkbox"/> Comm. Health Center <input type="checkbox"/> OTHER		
<input type="checkbox"/> HHC Hosp. Clinic <input type="checkbox"/> Vol. Hosp. Clinic <input type="checkbox"/> SHP in School		

RECOMMENDATIONS/REFERRALS

FULL PHYSICAL ACTIVITY RESTRICTIONS
Specify limitations and/or special alerts (i.e. allergies, medications, precautions)