



COUNTRY DAY SCHOOL  
OF ARLINGTON  
MONTESSORI PROGRAM  
*established 1959*

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Student Name

# Application for Admission 2024—2025

# Student Information

Please print

Full Name: \_\_\_\_\_  Male  Female

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Racial / Ethnic Group (Optional):  African American  Asian  Caucasian  Multi Racial  
 Hispanic  Middle-Eastern  Native American  Other

Applying for:  Academic School Year (Aug. 12 2024— May 23, 2025)  My child will attend Summer Program 2024  
Academic School Year Class Schedule  M  T  W  TH  F  8:15AM-3:30PM OR  Half Day

### Email addresses to be used for all school communication and billing purposes:

- Primary Email address: \_\_\_\_\_  Father  Mother  Other
- Secondary Email address: \_\_\_\_\_  Father  Mother  Other

# Mother / Guardian Information

Dr. / Mr. / Mrs. / Ms. \_\_\_\_\_

Home Address \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

If you wish to receive text communication, provide your mobile service carrier: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_

# Father / Guardian Information

Dr. / Mr. / Mrs. / Ms. \_\_\_\_\_

Home Address \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

If you wish to receive text communication, provide your mobile service carrier: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_

Parents / Guardians:  Married  Separated  Divorced  Widowed  Unmarried

Who has legal custody of the child? \_\_\_\_\_

### ***If parents/guardians do not live together:***

Please indicate with whom the child lives: \_\_\_\_\_

Are both biological parents to receive evaluations, report card, or academic information via Montessori

Compass and/or email?  Yes  No

Additional Comments: \_\_\_\_\_

# Sibling Information

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

# Previous School Information

Last School Attended: \_\_\_\_\_ Principal/Teacher: \_\_\_\_\_

School Address: \_\_\_\_\_ Dates Attended: \_\_\_\_\_

# Medical Information & Consent Form

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ALLERGIES:** \_\_\_ No \_\_\_ Yes     **EPI PEN:** \_\_\_ No \_\_\_ Yes     **INHALER / NEBULIZER:** \_\_\_ No \_\_\_ Yes

Anything listed here needs to be supported by a healthcare professional *in writing* (Physician or Licensed Dietitian).

Describe the child's health (including allergies, physical and/or medical considerations, recent illnesses) that may have affected, or may affect their performance in school:

\_\_\_\_\_  
 \_\_\_\_\_

## AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

**In the event I cannot be reached during a medical emergency**, I hereby give the staff at **Country Day School of Arlington** authorization to make arrangements for emergency medical care. I authorize emergency medical personnel or the person in charge to take my child to:

**PHYSICIAN:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred **HOSPITAL:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

I give consent for the facility to secure any and all necessary medical care for my child.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### TO BE COMPLETED BY THE CHILD'S PHYSICIAN

**CDSA FAX: 817-275-0263**

\*Please **attach** immunization records or fill in the chart below.

**Physician signature and date required.**

	DATE 1st dose	DATE 2nd dose	DATE 3rd dose	DATE 1st booster	DATE 2nd booster
Hepatitis B (HepB)	_____	_____	_____	_____	_____
Diphtheria, Tetanus, Pertussis (DTaP)	_____	_____	_____	_____	_____
Haemophilus influenza b (Hib)	_____	_____	_____	_____	_____
Pneumococcal (PCV)	_____	_____	_____	_____	_____
Inactivated Poliovirus (IPV)	_____	_____	_____	_____	_____
Influenza	_____	_____	_____	_____	_____
Measles, Mumps, Rubella (MMR)	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____
Hepatitis A (HepA)	_____	_____	_____	_____	_____
TB Test	Date: ____/____/____	Results: _____			

\***Any vaccine exclusion for medical reasons requires physician documentation.** If positive, physician statement is necessary for admission. Results from vision and hearing screening are required for students 4 years and older. Attach additional documentation if necessary.

Vision Screening: \_\_\_\_/\_\_\_\_/\_\_\_\_     Hearing Screening: \_\_\_\_/\_\_\_\_/\_\_\_\_

This child was examined by me on \_\_\_\_/\_\_\_\_/\_\_\_\_ and is physically able to participate in the school program. *Exceptions are noted on the back of this form.*

Physician's signature: \_\_\_\_\_ Phone \_\_\_\_\_

Required Document - pg2

# Dismissal Authorization

The following parents / guardians are authorized to pick-up my child

Driver's license number and the state issued must be listed for all individuals - no exceptions

\_\_\_\_\_  
Mother / Guardian State & DL #:

\_\_\_\_\_  
Father / Guardian State & DL #:

## **EMERGENCY DISMISSAL CONTACT AUTHORIZATION:**

The following persons (2 minimum) are authorized to pick-up my child. These individuals may be contacted by the school in the event that a parent / guardian cannot be reached during an emergency.

Driver's license number and the state issued must be listed for all individuals - no exceptions

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ )  
Home # ( \_\_\_\_\_ ) Work # ( \_\_\_\_\_ )

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ )  
Home # ( \_\_\_\_\_ ) Work # ( \_\_\_\_\_ )

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ )  
Home # ( \_\_\_\_\_ ) Work # ( \_\_\_\_\_ )

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ )  
Home # ( \_\_\_\_\_ ) Work # ( \_\_\_\_\_ )

# Dismissal Authorization

The following ***additional*** persons are authorized to pick-up my child

*Driver's license number and the state issued must be listed for all individuals - no exceptions*

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

\* Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
DL #: \_\_\_\_\_ DL State \_\_\_\_\_ Cell # ( \_\_\_\_\_ ) \_\_\_\_\_  
Home # ( \_\_\_\_\_ ) \_\_\_\_\_ Work # ( \_\_\_\_\_ ) \_\_\_\_\_

## Authorization

I hereby give the staff at Country Day School of Arlington authorization: *(check all that apply and initial as requested)*

- \* **PHOTOGRAPHY AND/OR QUOTE:** all students' photographs will be included in the internal school parent communication portal, Montessori Compass.
- \* I hereby -give -do not give my consent for my child's photograph or quote to be used in advertisements and/or external marketing.
- \* **WATER ACTIVITIES:** I hereby -give -do not give my consent for my child to participate in water activities. (These activities typically include sprinklers, slip-n-slide, water games and small kiddy pools.) All activities are with adult supervision.
- \* **INSECT REPELLANT:** I hereby -give -do not give my consent for my child to receive insect repellant provided by either the parent or CDSA.
- \* **SUNSCREEN:** I hereby -give -do not give my consent for my child to receive sunscreen provided by either the parent or CDSA.
- \* **SNACK**  I acknowledge that I will provide a DAILY snack and lunch or choose a lunch selection from the vendor chosen by the school. \_\_\_\_\_initial

## Grandparent Information

**MAIL SCHOOL MATERIAL** May CDSA mail school material to the grandparents? -Yes -No

*For example: Invitations to Grandparents/Special Friends Day*

\* **Maternal** Grandparents \_\_\_\_\_

Address \_\_\_\_\_

\* **Paternal** Grandparents \_\_\_\_\_

Address \_\_\_\_\_

# Extended Day Program Agreement

2024 - 2025 Academic School Year

- Extended Day is available on a drop in or discounted monthly agreement basis for before-school, after-school, and/or holiday care. I understand that I have accepted financial responsibility to pay the following:
  - \* **Drop-in** care is available at a rate of 10¢ a minute between 7-8AM and/or 3:30-6PM.
  - \* **Monthly Plans** are available for full-time and part-time schedules and are detailed in the chart titled *2023-2024 Extended Day Rates*. Rates may also be viewed at [www.cdsa.org](http://www.cdsa.org).
  - \* A **Full Extended Day Plan** option is available as a 9-month agreement for the Academic School Year (September 2024 - May 2025) which includes all available Extended Day (7-8AM, 3:30-6PM, and all Holiday Care) at a rate of \$270/month.
  - \* **Holiday Care** is available by registration for select school holidays as indicated on the 2023-2024 Academic School Year Calendar. Holiday care is billed in addition to monthly fees unless enrolled in the Full Extended Day Plan. Holiday Care from 8:15AM-3:30PM is \$45. Extended hours are available on Holiday Care days from 7-8AM and 3:30-5:30PM at a rate of 10¢ a minute.
  - \* With the exception of August, which will be prorated, I understand that monthly rates have been set according to the total number of days offered. In cases of abbreviated days of attendance, such as Winter Break, I understand that my fee will remain the same.
  - \* Changes made to a monthly agreement after the 1<sup>st</sup> of any given month will not go into effect until the following month. Any changes to a plan must be submitted in writing on the *Extended Day - Change of Schedule* form obtained by request from Administration.
- I understand that it is my responsibility to review my plan choice if I choose to enroll my child in an afterschool class. CDSA does not charge for Extended Day during the time of an afterschool class. An *Extended Day- Change of Schedule* form can be obtained from Administration - if an plan change is desired.
- I understand that I, or any agent of mine, will need to sign my child out on the Procure touchscreen located in the school foyer and follow the prompts. If I fail to sign my child out I will be charged for care until 6PM.
- I have been provided a copy of the CDSA 2024-25 school year calendar. **Please note: CDSA will not offer Extended Day on August 5, September 2, November 27, 28, 29, December 24, 25, 26, 31. January 1, 2, and May 27.**

**IMPORTANT INFORMATION:** Extended Day cell phone: 817-253-9994

**Emergency: Joyce Hunt: 817-723-1860**

**INCLEMENT WEATHER:** school closings broadcasted on NBC5, WFAA 8, KTVT 11, and posted [www.cdsa.org](http://www.cdsa.org)

## Extended Day Agreement

Please refer to *EXTENDED DAY— INFORMATION & RATES* and select one of the three options below:

- Drop-In:** care as needed
- Monthly Plan:**  the days / timings desired
- |                        |   |     |   |     |   |     |    |     |   |     |
|------------------------|---|-----|---|-----|---|-----|----|-----|---|-----|
| MORNING from 7 to 8AM  | M | ___ | T | ___ | W | ___ | TH | ___ | F | ___ |
| AFTERNOON until 4:30PM | M | ___ | T | ___ | W | ___ | TH | ___ | F | ___ |
| AFTERNOON until 6:00PM | M | ___ | T | ___ | W | ___ | TH | ___ | F | ___ |

**Full Extended Day Plan**

Child's name: \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**I confirm that I have read and agree to the CDSA Extended Day Program Agreement.**

- \* To be in **compliance with the State of Texas**, all required CDSA Admission Documents must be on file in the CDSA office.
- \* Please update your child’s health information, dismissal instructions, and contact information as needed. Immunization records must be updated and submitted regularly throughout the school year.
- \* A non-refundable \$100.00 enrollment fee and a non-refundable \$500 tuition deposit must accompany all applications.  Please charge Tuition Express: \_\_\_\_\_ initial

I have carefully reviewed the questions on the  
**APPLICATION FOR ADMISSION** to Country Day School of Arlington  
 and have answered them fully and to the best of my knowledge.

_____	_____	_____
Signature of Mother / Guardian	Printed Name	Date
_____	_____	_____
Signature of Father / Guardian	Printed Name	Date

**END OF APPLICATION**

Please submit to :

Country Day School of Arlington  
 1105 W. Randol Mill Road  
 Arlington, TX 76012  
 Fax: 817-275-0263  
 Email: [admin@cdsa.org](mailto:admin@cdsa.org)

Revised 04/03/2024





# Tuition Express Parent Authorization Agreement

CDSA offers you the convenience of **automatic tuition payments** through Tuition Express.

Tuition Express is encouraged for all school related expenses. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition and other school expenses have been paid on time. It is easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, please visit [www.tuitionexpress.com](http://www.tuitionexpress.com).



2024—2025 Tuition Express

**I authorize Country Day School of Arlington to withdraw sufficient funds to pay my child's:**

- Regular school tuition and other school related fees that are due and payable (Extended Day, Activity/Resource Fee)
- Regular school tuition only
- Summer program tuition only
  - Please process on the 15th of the month
  - Please process in one lump sum

Child's name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian                      Date                      Phone #

\* Credit Cards accepted: Visa and Master Card





# Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

## ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) \_\_\_\_\_ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. \_\_\_\_ (initial) Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

### COMPLETE ONE SECTION ONLY

#### SECTION A (Credit Card)

Cardholder Name _____		Phone # _____	
Cardholder Address _____	City _____	State _____	Zip _____
Account Number _____	Expiration Date _____	cvv # _____	
Cardholder Signature _____			Date _____

#### SECTION B (Bank Account)

Your Name _____		Phone # _____	
Address _____	City _____	State _____	Zip _____
Bank or Credit Union Name _____	Bank or Credit Union Address _____	City _____	State _____ Zip _____
Routing Transit Number (see sample below) _____	Account Number (see sample below) _____	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Authorized Signature _____			Date _____

#### For Official Use Only

Date Received
Employee Signature



A service of



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2024—2025 Tuition Express

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**- Pledge to Follow the Mitigation Plan of Country Day School of Arlington  
2024-25 Academic School Year**

By signing below, I agree to abide by all the terms and guidelines outlined in this Mitigation Plan.

I understand the importance following this Plan as it relates to the overall safety of all children and staff. I acknowledge that participation at CDSA involves risk.

I understand the pandemic policies as outlined in the 2024-25 pandemic handbook.

Student Name(s) printed:

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Parent Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date