



COUNTRY DAY SCHOOL
OF ARLINGTON
MONTESSORI PROGRAM
established 1959

Student Name

Application for Admission 2026—2027

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.10 2026— May 19, 2027) My child will attend Summer Program 2026
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.
- * **INSECT REPELLANT:** I hereby -give -do not give my consent for my child to receive insect repellent 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

2026 - 2027 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 *Extended Day Rates*. Rates may also be viewed at www.cdsa.org. **Extended Day Plans begin September 1, 2026 and will end May 19, 2027.**
 - * A **Full Extended Day Plan** option is available as a 9-month agreement (September 1, 2026 - May 19, 2027 August not included) for the Academic School Year, 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 2026-2027 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 \$35. Extended hours are available on Holiday Care days from 7-8AM and 3:30-6:00PM 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 1st 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 after-school 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 the Bulletin board on Montessori Classroom Share - if an plan change is desired.
- I have been provided a copy of the CDSA 2025-26 school year calendar.

Please note: CDSA will not offer Extended Day on August 3, September 7, November 25, 26, & 27, and December 23, 24, 25, & 31 of 2026. January 1 & 4, and May 20, 21, & 31 of 2027.

IMPORTANT INFORMATION: Extended Day cell phone: 817-253-9994
Emergency: Joyce Hunt: 817-723-1860
INCLEMENT WEATHER: School closings broadcasted on NBC 5, WFAA 8, KTVT 11, and posted www.cdsa.org

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

Extended Day Agreement

- 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** see description above.

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

Child's name: _____

Signature of Parent/Guardian _____ Date _____

- * 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

Revised: 02/18/2026





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



Copyright Procure Software 3/15/16



**- Pledge to Follow the Mitigation Plan of Country Day School of Arlington
2026-27 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 2026-27 pandemic handbook.

Student Name(s) printed:

Parent Signature

_____/_____/_____
Date