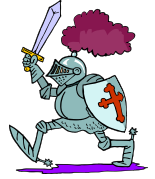




# Preschool / Jr. Kindergarten Registration Form



STUDENT'S Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  Male  Female

Returning Student  New Student If new, last pre-school attended (if any): \_\_\_\_\_

Registering for: (Students must have applicable birth date on or prior to August 15)

**3 yr. Preschool**  5 full  5 half  3 full  3 half  2 full  2 half

**4 yr. Jr. K**  5 full  5 half  3 full  3 half  2 full  2 half

Part time programs are restricted to 3 days (M-W-F) or 2 days (T-Th) with no exceptions.

Religious Affiliation (optional): \_\_\_\_\_ Congregation: \_\_\_\_\_

Father's Name: _____	* Required email address: _____
Address: _____	City: _____ State: _____ ZIP: _____
Home Phone: (____) _____	Work Phone: (____) _____ Cell Phone: (____) _____
Place of Employment: _____	Occupation: _____

Mother's Name: _____	* Required email address: _____
(If different) Address: _____	City: _____ State: _____ ZIP: _____
Home Phone: (____) _____	Work Phone: (____) _____ Cell Phone: (____) _____
Place of Employment: _____	Occupation: _____

Billing Information (If different): Name: _____	* Required email address: _____
Address: _____	City: _____ State: _____ ZIP: _____
Home Phone: (____) _____	Work Phone: (____) _____ Cell Phone: (____) _____

**\* All account/billing statements will be sent via e-mail unless home e-mail is unavailable**

<b>ADDITIONAL FAMILY DATA:</b> <i>If there is a separation or divorce in the family or if the student resides with a legal guardian, please complete this section</i>	
Name of Legal Guardian: _____	Relationship to Student: _____
Address: _____	City: _____ State: _____ ZIP: _____
Home Phone: (____) _____	Work Phone: (____) _____ Cell Phone: (____) _____
If separated or divorced, with which parent does the child reside? _____	
If divorced, please indicate the type of custody ordered by the court: <i>(Please attach a copy of the court's decision regarding custody.)</i>	<input type="checkbox"/> Joint <input type="checkbox"/> Sole
To whom should notices of school activities be sent? _____	
To whom should statements be sent? _____	

(additional information required on back of form)

# Emergency Authorization

I, \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_, a student at Riverside Christian Academy (RCA), grant Riverside Christian Academy permission to seek emergency medical care for my child and to make medical decisions on his or her behalf if I am unable to be reached in a timely manner.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Describe anything concerning your child that you feel we need to know (example: food or other allergies, certain habits, special needs or medical conditions, etc...)

\_\_\_\_ None

What form of discipline do you use at home? (spanking, time out, etc...) \_\_\_\_\_

## **Pick-up Authorization:**

The following individuals are authorized to pick my child up from school:

R.A.C.E. personnel (if applicable) \_\_\_\_\_

For safety reasons, identification may be required before a child is released. Parents should provide written permission when someone other than individuals listed above are to pick up their child.

## **Emergency Contact Numbers:**

Child's Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

In the case of emergency, the following individuals should be contacted if the student's parent is not able to be contacted:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please **circle** your choice of tuition payment options:

	<i>July 1</i>	<i>July 1 &amp; Dec. 1</i>	<i>Aug. 1 - May 1</i>	<i>June 1 - May 1</i>
<b>TUITION:</b>	<u>Annual</u>	<u>Semi-Annual</u>	<u>10 Month</u>	<u>12 Month</u>
Pre-school & Jr. K (1/2 day)	\$2,600	\$1,300	\$265	\$222.08
Pre-school & Jr. K (full day)	\$3,800	\$1,900	\$385	\$322.08

2 & 3 day options are subject to availability. Check with the office on status and pricing.



**REGISTRATION FEE:** \$130

I agree to adhere to policies of Riverside Christian Academy. By signing this agreement, I accept financial responsibility for tuition payment.

\_\_\_\_\_  
Signed (Parent or Guardian)      / /  
Date

# Health Information for:

\_\_\_\_\_  
*Student Name*

1. Is student under medical treatment at this time? Yes \_\_\_ No \_\_\_ If yes, please describe including a list of all medications given at home:

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2. Has student had any serious injuries, illnesses, accidents or been hospitalized recently? Yes \_\_\_ No \_\_\_ If yes, please describe:

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3. Is student required to have daily medications or medical treatments during school hours? This includes asthma inhalers, breathing treatments, injections, topical creams, and oral medications. These require a medication consent form (located on RenWeb). Please list all medications and treatments below:

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4. Is Child Allergic to any of the following:

Foods _____	Reaction _____	Treatment _____
Medications _____	Reaction _____	Treatment _____
Insects _____	Reaction _____	Treatment _____
Chemicals _____	Reaction _____	Treatment _____
Seasonal Allergies _____	Reaction _____	Treatment _____

If medication is needed for any of the above, please complete a medication consent form found on RenWeb.

5. Health Problems: Please mark all that apply and describe the health problem(s) along with any medication or treatment needed.

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> HEARING IMPAIRMENT
<input type="checkbox"/> ASTHMA/BREATHING PROBLEMS	<input type="checkbox"/> HEMOPHILIA/BLEEDING DISORDER
<input type="checkbox"/> BOWEL/INTESTINAL PROBLEMS	<input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE
<input type="checkbox"/> CARDIAC/HEART PROBLEMS	<input type="checkbox"/> NEUROLOGICAL/BIRTH DEFECT
<input type="checkbox"/> CANCER/LEUKEMIA	<input type="checkbox"/> PHYSICAL IMPAIRMENT
<input type="checkbox"/> DENTAL PROBLEMS	<input type="checkbox"/> SKIN DISORDERS
<input type="checkbox"/> DIABETES/HYPOGLYCEMIA	<input type="checkbox"/> STOMACH PROBLEMS/ULCERS
<input type="checkbox"/> EPILEPSY/SEIZURES/CONVULSIONS	<input type="checkbox"/> URINARY/KIDNEY/BLADDER PROBLEMS
<input type="checkbox"/> HEADACHES-frequent requiring medication	<input type="checkbox"/> VISION PROBLEMS
<input type="checkbox"/> HEADACHES-migraine	<input type="checkbox"/> OTHER PROBLEMS
<input type="checkbox"/> HEADACHES-sinus	

Explanation of health problems marked above: \_\_\_\_\_

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Does student have any limitations that prevent him/her from participating in physical education or school sponsored activities?

If so, please describe and send a physician's statement regarding limitations: \_\_\_\_\_

I give consent for my child to receive first aid at school for minor injuries, insect bites or small accidents that occur. At times, hydrogen peroxide, antibiotic ointment and anti-itch creams may be used if necessary.

\_\_\_\_\_  
Parents signature

\_\_\_\_\_  
Date