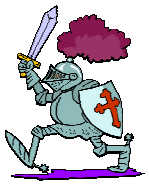
Preschool / Jr. Kindergarten Registration Form



Student Name: _____ Birth Date: ____/____/____ Grade: _____ ☐ Male ☐ Female
First / Middle / Last *Month / Date / Year* *2019-20*

☐ 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.

Father's Name: _____ email address: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Occupation: _____

Mother's Name: _____ email address: _____

Address: _____ City: _____ State: _____ ZIP: _____
(If different)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Occupation: _____

Billing Information ***(If different)***:

Name: _____ 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***

ADDITIONAL FAMILY DATA: *If there is a separation or divorce in the family or if the student resides with a legal guardian, please complete this section*

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: ☐ Joint ☐ Sole
(Please attach a copy of the court's decision regarding custody.)

To whom should notices of school activities be sent? _____

To whom should statements be sent? _____

(additional information required on back of form)
Revised 1/31/19

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: _____

	July 1	*July 1 & Dec. 1*	*Aug. 1 - May 1*	*June 1 - May 1*
TUITION:	Annual	Semi-Annual	10 Month	12 Month
Pre-school & Jr. K (1/2 day)	$2,700	$1,350	$275	$230.42
Pre-school & Jr. K (full day)	$3,900	$1,950	$395	$330.42

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

REGISTRATION FEE: $130

Fees will be posted to your Parents Web general account.

Choose one of the following options for your tuition payments. Changes may be made at any time by contacting the RCA accounting office.

☐ Annual ☐ Semi-Annual ☐ 10 Month ☐ 12 Month

☐ 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:

   _____

   _____

2. Has student had any serious injuries, illnesses, accidents or been hospitalized recently? Yes___ No___ If yes, please describe:

   _____

   _____

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:

   _____

   _____

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.

____ ADD/ADHD
____ ASTHMA/BREATHING PROBLEMS
____ BOWEL/INTESTINAL PROBLEMS
____ CARDIAC/HEART PROBLEMS
____ CANCER/LEUKEMIA
____ DENTAL PROBLEMS
____ DIABETES/HYPOGLYCEMIA
____ EPILEPSY/SEIZURES/CONVULSIONS
____ HEADACHES-frequent requiring medication
____ HEADACHES-migraine
____ HEADACHES-sinus
____ HEARING IMPAIRMENT
____ HEMOPHILIA/BLEEDING DISORDER
____ HYPERTENSION/HIGH BLOOD PRESSURE
____ NEUROLOGICAL/BIRTH DEFECT
____ PHYSICAL IMPAIRMENT
____ SKIN DISORDERS
____ STOMACH PROBLEMS/ULCERS
____URINARY/KIDNEY/BLADDER PROBLEMS
____VISION PROBLEMS
____OTHER PROBLEMS

Explanation of health problems marked above:_____

_____

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