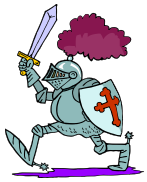
# Preschool / Jr. Kindergarten Registration Form



Student Name: _____ Birth Date: ____/____/____ Grade: _____ ☐ Male ☐ Female
*First / Middle / Last* *Month / Date / Year* *2021-22*

☐ 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: _____

***REQUIRED FOR NEW FAMILIES:***
***Please specify one FACTS customer.*** This parent (or other designated individual) will be the primary financial representative in FACTS to whom all invoices and statements will be sent.

Name: _____ email address: _____

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

**** 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 2/1/21*

# 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: _____

---

| TUITION: | Annual Tuition | *July 1* Full Year 2% Discount | *July 1 & Dec. 1* Semi-Annual 2% Discount | *Aug. 1 - May 1* 10 Months | *June 1 - May 1* 12 Months |
|---|---|---|---|---|---|
| Pre-school & Jr. K (1/2 day) | $3,115.00 | $3,052.70 | $1,526.35 | $311.50 | $259.58 |
| Pre-school & Jr. K (full day) | $4,450.00 | $4,361.00 | $2,180.50 | $445.00 | $370.83 |

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

*Fees will be posted to your Family Portal general account.* REGISTRATION FEE: $150

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

☐ Full Year ☐ Semi-Annual ☐ 10 Month ☐ 12 Month

RCA RIVERSIDE CHRISTIAN ACADEMY

☐ 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