ROWLETT, TEXAS
WESLEYAN
CHRISTIAN ACADEMY

Enrollment Form 2019-2020

August 19, 2019 – May 14, 2020

Date _____ **Emergency Code Word** _____

Current WCA student: Y N First Rowlett Member: Y N Enrolling sibling(s)?: Y N

_____

Child's Last name **First name** **Middle name**

_____ _____ _____ _____

Preferred name (if any) **Sex** **Date of birth** **Age as of 9-01-19**

_____

Child's Address: **City** **State** **Zip**

Mother/Guardian: _____ **Primary Phone**: _____

Occupation: _____ **Work Phone**: _____

Email: _____ **Alternate Phone**: _____

Father/Guardian: _____ **Primary Phone**: _____

Occupation: _____ **Work Phone**: _____

Email: _____ **Alternate Phone**: _____

*Designate at least one person **other than parents** as an* **Emergency** *contact:*

Name: **Home Address:** **Phone:** **Relationship:**

_____ _____ _____ _____

If no one chosen as an Emergency Contact, a parent must sign & date above line.

List other persons allowed to pick up your child from WCA.

Name: **Phone:** **Relationship to student?**

_____ _____ _____

_____ _____ _____

_____ _____ _____

2019-2020 School Year Program Choices

Annual Registration Fees

(All registration fees are non-refundable & are pro-rated based on month of enrollment.)

2 days- $100 3 days- $150 5 days- $250

Supply Fees

$35 per child due Sept. 1st $35 per child due Jan. 1st

Monthly Tuition Rates

(Due by 1st of each month: August - May)

Please check the desired program and age group.

	Infants	Toddlers/ Two Year Olds	Pre-K Threes/Fours	Kindergarten
Regular School Hours: 9 am to 2 pm				
TTH	_____ $225.00	_____ $205.00	_____ $190.00	
MWF	_____ $320.00	_____ $300.00	_____ $275.00	
M-F	_____ $510.00	_____ $490.00	_____ $470.00	_____ $470.00
Regular Plus Extended Care Hours: 7:30 am to 5:30 pm				
TTH	_____ $330.00	_____ $310.00	_____ $305.00	
MWF	_____ $470.00	_____ $450.00	_____ $445.00	
M-F	_____ $750.00	_____ $730.00	_____ $725.00	_____ $720.00

Authorization for Medical Treatment

In the event that I cannot be reached to make arrangements for medical treatment, I authorize any representative of Wesleyan Christian Academy to administer first aid and/or transport my child _____ to Baylor, Scott & White Medical Center – Lakepointe at 6800 Scenic Dr., Rowlett, TX 75088. I authorize and hereby give my consent for any necessary medical treatment, emergency or otherwise, furnished by any licensed physician, hospital or emergency treatment clinic (health care provider), and I agree to pay all medical fees incurred in connection with the treatment of my child under the authority granted herein. I hereby release Wesleyan Christian Academy, any health care provider, and any of their respective agents, employees, officers or representatives from any and all liability for any action taken on behalf of my child pursuant to the terms of this medical authorization.

_____

Signature of parent or legal guardian (must be signed before notary public) Date

Notary Public: Sworn to and subscribed before me this

_____ day of _____, 20_____

_____

Notary Public Signature (Print or type name)

Special conditions, allergies, required medications

Existing Illness or Condition:_____

_____

Diagnosed Allergy: _____
(Must complete and return Emergency Care Plan with physician signature)

Food Sensitivity/Intolerance: _____

Daily Prescription Medications: _____
Any WCA-administered medications must be signed in to WCA office. Please see parent handbook.

Media Permission

WCA _____ **has** _____ **does not have** my permission to display my child's photograph on the WCA website, Facebook page, flyers or other promotional materials. Names will never be used in conjunction with photos.

Agreement & Understanding - Please initial the following statements:

_____ I agree and understand that tuition, registration fee and supply fees are non-refundable.

_____ I agree and understand that tuition is due on my child's first class day of each month.

_____ I agree and understand that if I do not pay my tuition and/or outstanding balance by the 10th of the month, I will be charged a $25 late fee.

_____ I agree and understand that I will be charged a $25 fee for each program change made within the school year (adding extended care, changing days attended, etc.)

_____ I have received the WCA Parent Handbook for the 2018-2019 school year. I have read and accept the policies and regulations printed on this form as well as those printed in the WCA Parent handbook and I release it from any and all liability resulting from conditions or circumstances beyond its control.

Required Record Submission

I understand and will provide WCA with the following records for admission:

_____ Current immunization records or original notarized affidavit of exemption from immunizations.
_____ Signed/dated physician statement
_____ Hearing & Vision screening information (for children already 4 years old)

_____

Parent/Guardian Signature Date

WELLNESS STATEMENT, IMMUNIZATION INFORMATION, HEARING & VISION SCREENING

(To be completed by student's physician.)

Name of Child: _____Date of Birth: _____

THE FOLLOWING EXACT STATEMENT IS REQUIRED BY LAW IF NOT USING THIS SPECIFIC FORM.

DOCTOR'S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to participate in an early child development environment at Wesleyan Christian Academy.

***X*_____ _____**

(Required) Physician's Signature ***Date***

IMMUNIZATIONS*	DATE/DOSE 1	DATE/DOSE 2	DATE./DOSE 3	DATE/DOSE 4	DATE/BOOSTER
DPT/DTaP/DT					
POLIO IPV or OPV					
MMR					
HIB					
PNEUMOCOCCAL (Prevnar)					
Hepatitis A					
Hepatitis B					
Varicella (see below)					

**The physician's office may provide their immunization record for the student in place of completing this table.*

*The varicella (chickenpox) vaccine **is not required if a child has had the chickenpox disease**. If your child has had chickenpox, please complete the following statement:*

My child had varicella disease (chickenpox) on or about (date) _____and does not need varicella vaccine.

X_____ _____

Parent's signature for statement of chickenpox Date Signed

X_____ _____

Verifying Signature of Physician or Qualified Assistant Date Signed

Note: If medical diagnosis, treatment or immunizations conflict with your religious beliefs, or may be injurious to your child or family, you must obtain a state-approved certificate (signed by a physician) to that effect, and attach it to this form.

Texas State Law requires that ALL children 4 years old and older be screened for possible hearing and vision problems.

HEARING **Dr. Signature**_____ **Date** _____

Hz	500	1000	2000	4000	Pass [ ]
R					
L					Fail [ ]

VISION **Dr. Signature**_____ **Date** _____

R20/		L20/		Pass [ ]	Fail [ ]

ANY OF THE ABOVE INFORMATION MAY BE FAXED TO OUR OFFICE AT 972-412-4611