



Enrollment Form 2021-2022

August 9, 2021 – June 2, 2022

Date _____

Current WCA student: Y N

First Rowlett Member: Y N

Child's Last name _____ First name _____ Middle name _____

Preferred name (if any) _____ Sex _____ Date of birth _____ Age as of 9-01-21 _____

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

Mother/Guardian: _____ Primary Phone: _____

Name of Employer: _____ Work Phone: _____

Best E-mail: _____ Alternate Phone: _____

Father/Guardian: _____ Primary Phone: _____

Name of Employer: _____ Work Phone: _____

Best E-mail: _____ 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?** _____

Emergency Code Word _____

2021-2022 School Year Program Choices

Annual Registration Fees – Due at Enrollment

(All registration fees are non-refundable & will be pro-rated based on month of enrollment after start of school.)

2 days- \$100

3 days- \$150

5 days- \$250

Supply Fees

\$50 per child due Sept. 1st

\$50 per child due Jan. 1st

Monthly Tuition Rates

(Due by child's 1st day of class each month: August - May)

√ Please check the desired program and age group. √

	Infants	Toddlers/ Two Year Olds	Pre-K Threes/Fours	Kindergarten
Academic School Hours: 9 am to 2 pm				
TTH	_____ \$245.00	_____ \$215.00	_____ \$200.00	
MWF	_____ \$345.00	_____ \$315.00	_____ \$290.00	
M-F	_____ \$540.00	_____ \$510.00	_____ \$490.00	_____ \$500.00
Academic School Hours Plus Extended Care Hours: 7:30 am to 5:30 pm				
TTH	_____ \$355.00	_____ \$325.00	_____ \$320.00	
MWF	_____ \$500.00	_____ \$470.00	_____ \$465.00	
M-F	_____ \$790.00	_____ \$760.00	_____ \$755.00	_____ \$755.00

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 day of class 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 have received the WCA Parent Handbook for the 2021-2022 school year. I have read and I accept the policies and regulations printed on this form as well as those printed in the WCA Parent Handbook, and I release WCA from any and all liability resulting from conditions or circumstances beyond their control.

Photo Permission

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

WCA _____ has _____ does not have my permission to display my child's photograph via classroom specific venues (For example: Remind, Shutterfly or other private upload sites, e-mail, etc.)

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.

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 Wellness Statement (page 4 of this packet)

_____ Hearing & Vision screening information (for children already 4 years old)

Parent/Guardian Signature

Date

Authorization for Medical Treatment – Must be Notarized

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 contact Emergency Medical Services to assess and/or transport him/her to a medical facility. 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)

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 (Pevnar)					
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 []
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ANY OF THE ABOVE INFORMATION MAY BE FAXED TO OUR OFFICE AT 972-412-4611 or E-MAILED TO Roberta.Smith@firstrowlett.org.