# **Enrollment Application**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child’s Name: |  | Age: |  | Birth Date: |  |
| Mother’s Name: |  | Father’s Name: |  |
| **Mother’s Contact Information** |
| Employer: |  | Occupation: |  | Work Phone: |  |
| Home Phone: |  | Cell Phone: |  |
| Email Address: |  |  |
| **Father’s Contact Information** |
| Employer: |  | Occupation: |  | Work Phone: |  |
| Home Phone: |  | Cell Phone: |  |
| Email Address: |  |  |
| **In Case of Emergency (Parents/Guardians cannot be Emergency Contacts)** |
| Name: |  | Relationship: |  |
| Address: |  | Home Phone: |  | Work Phone: |  |
| Email Address: |  | Cell Phone: |  |
| Brief Overview of Medical History: |
|  |
|  |

|  |  |
| --- | --- |
| Are there any phobias, frequent bad dreams, etc.? |  |
| If yes, Explain: |  |
| Any prescribed medication(s)? |  |
| If yes, Explain: |  |
| Food allergies, please list: |  |
|  |

|  |
| --- |
| Please comment on any general or specific information that might help us to assist your child in any or all the following areas of growth: |
| Physical: |  |
| Intellectual: |  |
| Emotional: |  |
| Social: |  |
| Describe, in your own words, your child's general personality: |  |
|  |
|  |
|  |

# **Emergency Medical Authorization Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Child's Name: |  | Age: |  |
| Address: |  | Phone: |  |
| City: |  | State: |  | Zip: |  |
| Mother’s Name: |  | Day Phone: |  |
| Father’s Name: |  | Day Phone: |  |
| Other’s Name: |  | Day Phone: |  |

|  |
| --- |
| **TO GRANT CONSENT**: I hereby give consent for the following medical care providers and local hospital to be called in the event of a medical emergency: |
| Physician : |  | Phone: |  |
| Dentist: |  | Phone: |  |
| Medical Specialist: |  | Phone: |  |
| Local Hospital: |  | Phone: |  |

 *In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible.*

*This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentist concurring in the necessary for such surgery, are obtained prior to the performance of such surgery.*

*Facts concerning the child’s medical history, including allergies, medication being taken, any physical impairment to which a physician should be altered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Signature: |  |
| Address: |  | Zip: |  |

**REFUSAL TO GRANT CONSENT**:

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Signature: |  |
| Address: |  | Zip: |  |

 ***Please note: Bethel Christian Academy, Inc. will not provide educational or recreational services to families who refuse to grant consent for emergency medical treatment.***

# **Contractual Agreement**

I, (parent/guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to enroll my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_in Bethel Christian Academy, Inc.

I agree to:

1. Pay Bethel Christian Academy, Inc., a weekly fee of $185.00 to instruct and care for my child
2. Cooperate with Bethel Christian Academy, Inc.'s educational and recreational program to help meet the developmental needs of my child to the best of my ability.
3. Call in before 9:00 a.m. when my child will be absent or late.
4. Pay in full child's fee on Monday or 1st day my child's attendance for that week. I have furthermore been advised if checks are returned two (2) times, I must pay fees with money orders, cashier checks or cash along with a $50 returned check fee.

Reviewed all the policies for the payment of Bethel Christian Academy, Inc. fees and I agree to adhere to these policies.

I agree to pay $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per week for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Child’s Name) on Monday of every week.

|  |  |
| --- | --- |
| Print Name: |  |
| Signature: |  | Date: |  |

Starting Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who will drop off your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ a.m.

Who will pick up your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ p.m.

# **Pickup Authorization**

|  |
| --- |
| Please list the name(s) of person(s) who are authorized to bring and/or pick-up your child from Bethel Christian Academy, Inc. |
| **1** | Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  |  |
| **2** | Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  |  |
| **3** | Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  |  |

|  |
| --- |
| Please list below any additional name(s) of persons who are authorized to bring and/or pick up your child at any time at Bethel Christian Academy, Inc. |
| **1** | Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  |  |
| **2** | Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  |  |
| **3** | Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  |  |

Identification will be expected from anyone other than parent(s)/guardian(s) when picking up child. If the child is to be picked up by someone other than the names listed above, the parent must advise in writing and follow up with a phone call to the office.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |