

Student Name: \_\_\_\_\_

**VPK Application Process Checklist**

VPK 4-Day    VPK 5-Day

- Completed CCA Application
- VPK Voucher
- Consent for Treatment
- Off Campus Release
- Birth Certificate
- Immunization Record-Blue Card- Expires \_\_\_\_\_
- Physical Examination-2 years or 1 year- Expires \_\_\_\_\_
- Parents Web account email

# CALVARY

## Chapel Academy

Where Faith and Learning Soar

### 2019-2020 VPK COMMITMENT

#### Melbourne Campus

#### REQUIRED DOCUMENTS:

- VPK Voucher \_\_\_\_\_
- Birth Certificate \_\_\_\_\_
- Immunization Form \_\_\_\_\_
- Physical Exam \_\_\_\_\_

#### FOR OFFICE USE ONLY

Date Rec'd \_\_\_\_\_  
Time Rec'd \_\_\_\_\_  
OPTIONAL ACTIVITY FEE \$ \_\_\_\_\_  
Check # \_\_\_\_\_  
Staff \_\_\_\_\_

#### Check the Appropriate Box:

VPK 4-Day     VPK 5-Day

#### I. PERSONAL DATA:

Student's Name \_\_\_\_\_  
(Last) (First) (Middle)

Name Student goes by: \_\_\_\_\_

Male/Female \_\_\_\_\_ SS Number \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Birth \_\_\_\_\_  
month/date/year

Race:  African-American     Asian     Caucasian     Hispanic     Native American     Other

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Email Address: \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Email Address: \_\_\_\_\_

With whom does the student live?

\_\_\_\_\_

Relationship to student: \_\_\_\_\_

Calvary Chapel Academy admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admissions policies, and athletic and other school administered programs.

**Child Custody**

(Legal documents must accompany this application.)

**If Parents are divorced or separated**, who has legal custody of the child? \_\_\_\_\_

**Is either parent forbidden by court** order from having equal access to the child or the school records?

No  Yes

If yes, name of parent who may not have equal access: \_\_\_\_\_

(Written documentation is required prior to enrollment.)

If there are other children in the family, complete the following:

Name: \_\_\_\_\_ Age/Grade: \_\_\_\_\_ / \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age/Grade: \_\_\_\_\_ / \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age/Grade: \_\_\_\_\_ / \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Age/Grade: \_\_\_\_\_ / \_\_\_\_\_ School: \_\_\_\_\_

List adults who will be permitted to pick up your child:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**II. MEDICAL INFORMATION:**

Name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

In the event of an emergency, the name and phone number to call if parent cannot be reached:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Special physical problems of student: \_\_\_\_\_

List any allergies (i.e. medical, etc.):

Is your child taking regular medication for any purpose? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please specify medication and explain (medication/dosage): \_\_\_\_\_

Is the student fluent in another language?  No  Yes If yes, what language? \_\_\_\_\_

Does the student read and write in this language?  No  Yes

**III. SCHOOL HISTORY:**

List the schools the student has previously attended (name and full address with zip code):

School	Dates and Grades Attended
Address _____	_____
_____	_____

School \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_ Dates and Grades Attended

Has your child ever been expelled or requested to withdraw from a school? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Grade \_\_\_\_\_ School \_\_\_\_\_ Reason \_\_\_\_\_  
Grade \_\_\_\_\_ School \_\_\_\_\_ Reason \_\_\_\_\_

If you are applying for admission to CCA when the school year is in session, please describe your reasons for withdrawing your child from his/her present school. \_\_\_\_\_

Has your child ever been retained? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, specify:  
Grade \_\_\_\_\_ School that retained \_\_\_\_\_ School where grade repeated \_\_\_\_\_

Why have you selected CCA for your child's education? \_\_\_\_\_  
\_\_\_\_\_

Please specify if your child has ever been tested for the following:

Speech \_\_\_\_\_ When \_\_\_\_\_ By whom \_\_\_\_\_  
Test results \_\_\_\_\_

Hearing \_\_\_\_\_ When \_\_\_\_\_ By whom \_\_\_\_\_  
Test results \_\_\_\_\_

Vision \_\_\_\_\_ When \_\_\_\_\_ By whom \_\_\_\_\_  
Test results \_\_\_\_\_

Please specify if your child currently has any of the following:

IEP \_\_\_\_\_ School Name/Location \_\_\_\_\_  
School District \_\_\_\_\_  
Is the IEP current? \_\_\_\_\_ yes \_\_\_\_\_ no

OTHER \_\_\_\_\_ Name/type plan? \_\_\_\_\_  
School name \_\_\_\_\_  
School district \_\_\_\_\_

Please specify if your child has ever been referred to or worked with the following:

Space Coast Early Intervention Center: \_\_\_\_\_ yes \_\_\_\_\_ no When \_\_\_\_\_ Reason \_\_\_\_\_  
Brevard Early Steps: \_\_\_\_\_ yes \_\_\_\_\_ no When \_\_\_\_\_ Reason \_\_\_\_\_  
Child Find: \_\_\_\_\_ yes \_\_\_\_\_ no When \_\_\_\_\_ Reason \_\_\_\_\_  
Easter Seals: \_\_\_\_\_ yes \_\_\_\_\_ no When \_\_\_\_\_ Reason \_\_\_\_\_  
Circles of Care: \_\_\_\_\_ yes \_\_\_\_\_ no When \_\_\_\_\_ Reason \_\_\_\_\_

***Although every effort will be made, Calvary Chapel Academy cannot promise or commit to remediate or address the special needs of a child, whether those special needs are/are not made known to the school by the parent.***

IV. BILLING INFORMATION:

Name of person responsible for this student's tuition and other expenses:

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

Financial information may also be released to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Activity/Registration Fee for 2019-2020**

<u>Program</u>	<u>Days</u>	<u>Time</u>	<u>Activity Fee</u>
VPK Program (5 Day)	M-F	8:15-11:45 a.m.	\$100.00*
VPK Program (4 Day)	M-TH	8:15-12:30 p.m.	\$100.00*

Activity fee for our VPK program, pursuant to the Office of Early Learning policy #OEL-PI-0027-05 is strictly optional. We encourage you to pay the \$100 activity fee as it is used to purchase materials to enhance the students educational experience.

**Tuition Fee for 2019-2020**

Program

VPK Program

*Paid By State of Florida*

**In the event my child is accepted for admission to CCA, I agree to the following: (Please initial following each item.)**

V. STUDENT/PARENT AGREEMENT: The undersigned parent(s) or legal guardian(s) of the above-referenced student agrees to abide by the policies, procedures, and rules set forth by CCA, and further recognizes the school's right to establish rules and provide for their enforcement. \_\_\_\_\_

Permission is hereby granted for the above-referenced student to be photographed for the purpose of possible use in marketing and/or advertising publications. This permission is applicable for current, as well as future project use. \_\_\_\_\_

Permission is hereby granted for the above-referenced student to be screened for specific educational needs. \_\_\_\_\_

Be advised that your child may be assessed for delayed standard development and/or growth using the Gesell Developmental Observation method if/when it is perceived necessary by the CCA teacher and administration. \_\_\_\_\_

VI. AUTHORIZATION FOR EMERGENCY CARE: The undersigned parent(s) or legal guardian(s) of the above-referenced student authorize officials of CCA/Calvary Chapel Melbourne to contact directly the persons named on an emergency information card maintained in the school office and authorize the named physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of the child. In the event the physician(s), other persons named above, or parent/guardian cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. Further, the undersigned parent(s) or legal guardian(s) of the above-referenced student will not hold CCA/Calvary Chapel Melbourne financially responsible for the emergency care and/or transportation for the above-referenced student. This authorization shall remain effective while the child is enrolled in CCA, unless sooner revoked in writing and delivered to CCA/Calvary Chapel Melbourne. \_\_\_\_\_

VII. I understand the service hour requirement as described in the Preschool Handbook, and am aware that I will be billed for any outstanding hours at the end of each school year. \_\_\_\_\_

IX. I am aware that I am responsible for providing supplies for each child following the parameters of the CCA Supply Lists. \_\_\_\_\_

X. I will read the Preschool Handbook and discussed any appropriate or pertinent information with my/our child(ren). I agree to abide by the policies and procedures as outlined in the Preschool Handbook and support the school in enforcing the school rules and discipline policies as outlined in the aforementioned Handbook. Failure to sign and return this form does not alleviate my responsibility to abide by all policies and procedures as stated in the handbook, particularly as it relates to discipline. \_\_\_\_\_

- XI. I understand the service hour requirement as described in the Preschool Handbook, and am aware that I will be billed for any outstanding hours at the end of each school year. \_\_\_\_\_
- XII. I am aware that I am responsible for providing supplies for each child following the parameters of the CCA Supply Lists.
- XIII. I will read the Preschool Handbook and discussed any appropriate or pertinent information with my/our child(ren). I agree to abide by the policies and procedures as outlined in the Preschool Handbook and support the school in enforcing the school rules and discipline policies as outlined in the aforementioned Handbook. Failure to sign and return this form does not alleviate my responsibility to abide by all policies and procedures as stated in the handbook, particularly as it relates to discipline.
- XIV. **REGISTRATION FORMS:** The undersigned parent(s) or legal guardian(s) of the above-referenced student understands that this VPK Commitment form and the completed Early Learning Coalition VPK Commitment form **MUST** be completed and on file in the school office before school begins. **Completion of this document is necessary for the student to ensure a space or to be placed on the wait list for the 2019-2020 school year.** \_\_\_\_\_

CALVARY CHAPEL ACADEMY

_____ Tim Flay, Principal	Dr. Mr. Ms. Mrs. _____ Signature of Parent/Guardian  Print Name: _____	_____ Date  _____ Phone No.
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Please Indicate:  
 How did you hear about CCA?

- \_\_\_\_\_ Drive By /Sign \_\_\_\_\_
- \_\_\_\_\_ Facebook/Website \_\_\_\_\_
- \_\_\_\_\_ Everything revarad \_\_\_\_\_
- \_\_\_\_\_ Friend/Referred by \_\_\_\_\_
- \_\_\_\_\_ CCM \_\_\_\_\_
- \_\_\_\_\_ Sibling \_\_\_\_\_
- \_\_\_\_\_ Word of Mouth \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

## OFF-CAMPUS RELEASE

Concerning: \_\_\_\_\_  
Name of Student

**THIS DOCUMENT IS APPLICABLE TO THE PERIOD OF TIME DURING WHICH YOUR CHILD ATTENDS CALVARY CHAPEL ACADEMY.**

- I. I authorize Calvary Chapel Academy, by its representative, to obtain any emergency medical care necessary.
  
- II. I agree that the expense of any medical treatment will not be covered by Calvary Chapel Academy or any of its employees.
  
- III. I will not hold Calvary Chapel Academy or any of its employees liable for any injury sustained by the student while traveling to, participating in, or returning from any Calvary Chapel Academy function.
  
- IV. I may be reached in case of emergency at: \_\_\_\_\_  
Phone Number  
The student is covered by: \_\_\_\_\_  
Name of Insurance Company  
Policy Number: \_\_\_\_\_
  
- V. I understand that every effort will be made to contact me regarding medical treatment authorization. If I am unavailable, please consider the following list of pertinent medical information: (Please include any allergies, last tetanus shot, medication, recent injuries, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC, STATE OF FLORIDA

Personally Known \_\_\_\_\_  
Produced Identification \_\_\_\_\_  
Type \_\_\_\_\_

## CONSENT FOR TREATMENT

**THIS DOCUMENT IS APPLICABLE TO THE PERIOD OF TIME DURING WHICH YOUR CHILD ATTENDS CALVARY CHAPEL ACADEMY.**

This form is necessary to have on hand in case an emergency arises at the school and treatment must be sought after every effort has been made to contact the parents, guardians, or persons noted on your child's emergency card.

I give permission for \_\_\_\_\_ to receive treatment by a physician or hospital emergency room personnel in the event that I cannot be reached by phone.

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Name

Please list any medical conditions or allergies below that pertain to your child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC, STATE OF FLORIDA

Personally Known \_\_\_\_\_  
Produced Identification \_\_\_\_\_  
Type \_\_\_\_\_