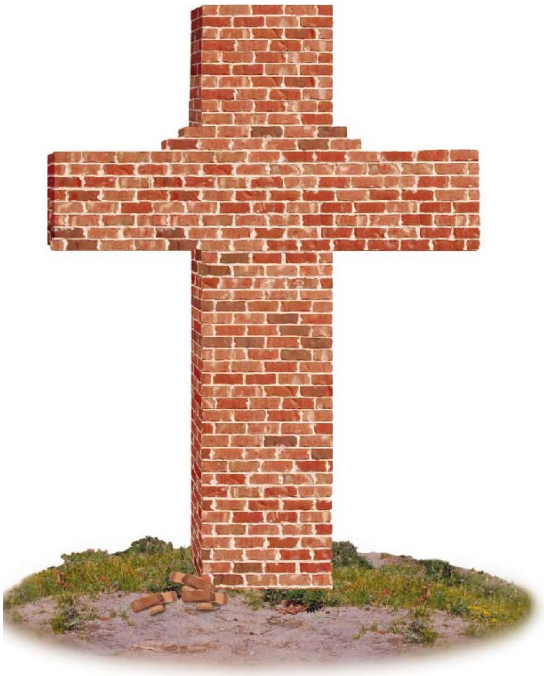
NEW CHAPEL CHRISTIAN ACADEMY
5601 OLD BRANCH AVENUE
CAMP SPRINGS, MARYLAND 20746
301-899-0877

# SUMMER CAMP
# ENROLLMENT PACKET



*DISCIPLE MAKERS FOR KINGDOM BUILDING*

**NEW CHAPEL BAPTIST CHURCH**
5601 Old Branch Avenue
Camp Springs, MD 20748
(301) 899-0877
**REV. DR. KERRY A. HILL, PASTOR**

## New Chapel Christian Academy (NCCA)

**Mailing Address:** 5601 Old Branch Avenue
Camp Springs, MD 20748

**Office Hours:** 6:00 a.m. – 6:00 p.m.
**Tour Hours:** 7:00 a.m. – 2:00 p.m. (all other times call for appointment)

**Telephone:** 301-899-0877
**Fax:** 301-899-0906

Executive Director ..... Rev. Dr. Kerry A. Hill, Pastor
Executive Director ..... Rev. Donna Hill, First Lady
Church Administrator ..... Deacon Dorothy Russell
Principal ..... Rev. Latarsha Jones
Vice Principal ..... Dr. Mary Eley
Preschool Vice Principal In training ..... Mrs. Kuiana Fair
Registrar ..... Mrs. Michelle Sterling
Finance ..... Min. Mary Scruggs
Assistant to the Pastor ..... Mrs. Lisa Eley
Dean of Parent Concerns ..... Rev. Chester Burke

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**The New Chapel Christian Academy would like to say thank you once again for choosing us for your child's summer camp needs.**

- **ONLY NEW PARENTS NEED TO FILL OUT MEDICAL FORMS**
- **Existing NCCA student slots are guaranteed for the summer program when parents return a completed packet along with $125.00 activity fee.**
- **New and Returning Summer Students slots are guaranteed for the summer program when parents return a completed packet along with their registration fee of $100.00 and activity fee of $125.00.**
- **All fees are nonrefundable.**

**Payments for Summer Program**
**$1,000.00 for the entire 8 week program**

**Tuesday, June 15, 2012 $500.00 due**
**Friday, July 13, 2012 $500.00 due**

**Please contact the school's registrar should you have additional questions or need assistance with the re-enrollment process.**

NEW CHAPEL CHRISTIAN ACADEMY
5601 Old Branch Avenue
Camp Springs, MD 20748

**Summer Camp Registration**

Please complete separate registration forms for each child and print clearly. This form may be photocopied

Child's Name _____

Sex _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Parent/Guardian #1 _____ Home Phone _____

Work # _____ Cell # _____ Email _____

Employer Address _____

Parent/Guardian #2 _____ Home Phone _____

Work # _____ Cell # _____ Email _____

Employer Address _____

Allergies _____ Doctor's Name _____ Phone # _____

Please Circle Only One:

| | | |
|---|---|---|
| Current Student | Yes | No |
| Returning Summer Student | Yes | No |
| New Student | Yes | No |

**NCCA Summer Camp Registration Checklist**
**(to be completed by office staff)**

Dear Summer Camp Parent:

All of the following documentations must be completed (for each child) on the day of registration or the Admission process will not be finalized. **NCCA existing student will not need to submit the medical forms. All other students must submit a copy of all medical forms either from current school or from medical provider.**

| | | **Receipt Date** |
|---|---|---|
| □ | Application | _____ |
| □ | Immunization Records | _____ |
| □ | Medical Evaluation | _____ |
| □ | Lead Test (only for students under age 6) | _____ |
| □ | Medical / Allergy Notification Form | _____ |
| □ | Financial Agreement | _____ |
| □ | Emergency Form | _____ |
| □ | Food Program Form | _____ |
| □ | General Permission Slip | _____ |

**No person will be denied admission based on race, color, sex, or national origin.**
**Thank you for your interest in New Chapel Summer Program.**

**REGISTRAR USE ONLY**

Date Returned _____

Registration Fee: $_____ Check/Money Order#_____ Credit Card_____

Activity Fee: $_____ Check/Money Order#_____ Credit Card_____

Grade (2012-2013)_____ Student's Name_____

***Note: $100 non refundable registration fee plus $125 activity fee for new and returning parents. All existing NCCA parents there is a $125 activity fee.***

**New Chapel Christian Academy**
**EMERGENCY / AUTHORIZATION PICK UP FORM**
**(this form must be filled out annually)**

**I authorize the following designee(s) to pick up the named student**

Child's Name _____ Birth date_____

Child's Home Address_____

Mother's Name_____ Home Telephone_____

Mother's Employer/School_____

Mother's Home Address *(if different from above)* _____

Work Telephone_____ Cellular Phone_____ **Email**_____

Father's Name_____ Home Telephone_____

Father's Employer/School_____

Father's Home Address *(if different from above)* _____

Work Telephone_____ Cellular Phone_____ **Email**_____

Emergency Contact _____ Relationship to Student _____

Home phone _____ Cell Phone _____ Other _____

Doctor's Name _____ Phone _____

Health Problems and or Allergies _____

**Authorization: I authorize New Chapel Christian Academy or its designee to transport the above named student to a hospital emergency room for treatment in the event of serious illness or injury if parent, guardian, or emergency contact cannot be reached. I understand that I am financially responsible for cost incurred.**

1. Name_____Relationship _____

Full Address_____

Home phone _____ Cell Phone _____ Other _____

2. Name_____Relationship _____

Full Address_____

Home phone _____ Cell Phone _____ Other _____

3. Name_____Relationship _____

Full Address_____

Home phone _____ Cell Phone _____ Other _____

Signature of parent/guardian _____ Date_____

**New Chapel Christian Academy**
**Summer Camp Financial Agreement**

20___ - 20___

| Student Name | Gender | DOB | Grade Level | New | Returning |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Please fill in the following as it appears on your account*

**BILLING**

Person Responsible for Payments (please print) _____
Billing Address _____ City _____State _____ Zip_____
Home Phone _____ Work Phone _____
Mother's Cell _____ Father's Cell _____
Email Address _____ (required)

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**GUARANTEE** (required for registration)
Credit Card Guarantee (please provide only one) _____**VISA** _____**MASTERCARD**
Cardholder's Name (as it appears on card) _____Exp Date _____
Credit Card Number _____ Last 3 Digits on back of card _____

**FINANCIAL POLICY**

All payments are due on the **fifteenth** of each month. This includes tuition and any other charges or fees. Payments begin June 15, 20 _____ and ending July 15, 20 _____. After the 15th of the month, a $50.00 late charge will be added to the account. If payment is not received by the 15th the above credit card will be charged on the next business day. If the credit card is declined, your child (ren) will not be allowed to attend classes until the account is up to date. Each month the balance on the account must come to a zero balance in order to avoid a $50.00 late fee.

- There is a $35.00 return check fee for "insufficient funds" after **one** NSF check has occurred, we can only accept money orders, cashier checks, or Visa/Mastercard as form of payment for the remainder of the school year. Please make sure to put your child (ren) name on all forms of payment for proper account recording.
- **Post dated checks will and cannot be accepted nor will allowance be made for alimony, child support, tax refunds, property sales, or other settlements.**
- Due to the computer software the finance office can only provide one statement per family to the person whose name appears on the account.
- All accounts must be up-to-date at the time of registration and kept up-to-date in order for students to remain active.
- Students are not considered officially registered for school any-time their accounts are in arrears. Another registration fee will be charged if the student is reinstated.
- All accounts must be paid-in-full by the end of the year or evaluations/report cards and records will be held.
- Registration fees are non-refundable.

I am responsible for payments and have read and agree to the financial polices of New Chapel Christian Academy as stated above. I authorize New Chapel Christian Academy to use the above credit card if payment is not received by 6 pm on the 15th of the month.

**Signed**_____ **Date** _____


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NEW CHAPEL CHRISTIAN ACADEMY
MEDICAL & ALLERGY NOTIFICATION FORM
Summer Camp 2012

Student Name: _____ Grade: _____

Date of Birth _____ Age: _____

Address: _____

City _____ State _____ Zip_____

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**Section I – Medical / Allergies**
**(Name of condition(s) and medication(s) described in the space below)**

Medical:_____

_____

Allergies: _____

_____

Allergy Type: ___Food __Airborne __Other _____

---

**Section II – Parent(s) Emergency Contact Information**

Mother: _____Work: _____ Cell: _____

Father: _____ Work: _____ Cell: _____

Other: _____ Work: _____ Cell: _____

---

**Section III – Physician's Emergency Contact Information**

Doctor's Name: _____

Address: _____

Telephone Number: _____

**Insured's Name: _____**

**Insurance Co. _____ Policy # _____**

Signature _____ Date_____

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

# HEALTH INVENTORY

## CHILD'S PERSONAL RECORD FOR CHILD CARE FACILITIES

**Child's Name**_____ _____
**Last** **First** **Middle** **Birth Date**

**Name of Parent or Guardian** _____ _____
**Relationship**

**Home Address** _____

**City**_____ **State** _____ **Zip Code** _____

**Check Best Telephone Number to Reach You:**

**Home #:** _____ **Work #:** _____ **Cell #:** _____

Dear Parent/Guardian:

Healthy children need medical and dental health supervision and should see a doctor at regular intervals. The health check-up should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health and individual needs information from you (Part I), which will be helpful to the Health Practitioner in evaluating your child, and medical information, lead screening/testing and proof of age-appropriate immunizations from your child's Health Practitioner (Part II). This information must be completed prior to your child being admitted to child care.

**Maryland law requires you to submit proof of age-appropriate immunizations and that children less than six years of age have appropriate screening for lead poisoning. Children who reside (or have ever resided) in certain areas of the State (see page 4) designated as at-risk for childhood lead poisoning must receive one or more blood lead tests at 12 and 24 months of age.**

**PLEASE RETURN THIS COMPLETED FORM TO:**

**Name of Child Care Facility:**_____

**Address:**_____

_____
**City/Town State Zip Code**

## PART I: CHILD'S HEALTH AND INDIVIDUAL NEEDS INFORMATION

*To be completed by* **PARENT/GUARDIAN** **CHILD'S NAME:** _____

**IMPORTANT:** COMPLETE PART I BEFORE THE HEALTH PRACTITIONER EXAMINES YOUR CHILD. TAKE THIS FORM WITH YOU TO THE HEALTH PRACTITIONER. PLEASE CHECK CORRECT ANSWERS TO THE FOLLOWING QUESTIONS IN COLUMNS ON THE RIGHT. Explanation, if needed, can be given in the space provided for "REMARKS".

| | YES | NO |
|---|---|---|
| 1. Are you concerned about your child's general health (*eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.)?* | _____ | _____ |
| 2. Does your child have any eye problems *(difficulty seeing, crossed eyes, frequently reddened or watery eyes)?* | _____ | _____ |
| Date of last eye examination: _____/ _____/ _____ Doctor's Name: _____ | | |
| Results: _____ | | |
| Does your child wear glasses? | _____ | _____ |
| Contact lenses? | _____ | _____ |
| 3. Does your child have any ear or hearing problems (*frequent earaches, difficulty hearing, etc.)*? | _____ | _____ |
| Date of last hearing evaluation _____/ _____/ _____ Doctor's Name: _____ | | |
| Results: _____ | | |
| Does your child use a hearing aid? | _____ | _____ |
| 4. Does your child have any speech problems *(difficulty having speech understood, stammering, delayed speech development, etc.*)? | _____ | _____ |
| 5. Does your child have any allergies? If YES, please state what kind of allergies: | _____ | _____ |
| 6. Does your child have any other specific illness, disability or other limiting condition? If YES, answer a, b and c: | _____ | _____ |
| (a) Does this condition require any special health care in the child care facility? | _____ | _____ |
| (b) Has your child received evaluation(s), which could help the child care provider or teacher in meeting his/her health or educational needs? | _____ | _____ |
| (c) Does your child require any special adaptations or adaptive equipment? | _____ | _____ |
| 7. Do you have concerns about your child's behavior or emotional well-being which the child care provider or teacher should know about? | _____ | _____ |
| 8. Do you have concerns about your child's social or developmental needs which the child care provider or teacher should know about? | _____ | _____ |

**REMARKS** (*Provide further explanation for all "YES" answers):*

_____

_____

_____

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE. **I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____ _____

**Signature of Parent/Guardian** **Date**

## PART II: MEDICAL INFORMATION

*To be completed by a* **HEALTH PRACTITIONER** **CHILD'S NAME:** _____

1. Date of this child's most recent tuberculin test: ___/ ___/___ Result: ____ Positive ____ Negative

**Under Maryland law, a child under the age of six must have appropriate screening/testing for lead poisoning. See page 4.**

2. Date of this child's lead screening: ___/___/___ Blood lead test dates: Test 1: ___/___/___ Test 2: ___/___/___

3. This child has the following which may significantly affect his/her child care experience: (COMMENTS)

| | | |
|---|---|---|
| a. Vision problem | YES NO | _____ |
| b. Hearing problem | YES NO | _____ |
| c. Speech or language problem | YES NO | _____ |
| d. Other physical illness or impairment | YES NO | _____ |
| e. Mental, emotional or behavior problems | YES NO | _____ |
| f. Developmental delays | YES NO | _____ |
| g. Allergies | YES NO | _____ |

Significant physical findings, comments and recommendations:

4. This child has a health condition which may require care or emergency action while at child care. YES NO

If YES, please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____

_____

Recommendations: _____

5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

YES NO If YES, please specify: _____

6. This child requires a modified diet and/or special feeding procedures. YES NO

If YES, please specify:

7. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

_____

8. Does this child's physical activity need to be restricted? YES NO

If YES, please specify: _____

9. Does this child require any specialized treatment? YES NO

If YES, please specify: _____

10. Does this child require any adaptive equipment (braces, crutches, etc.)? YES NO

If YES, please specify type: _____

Special instructions for use:

### RECORD OF IMMUNIZATIONS

| Vaccine Types<br>Enter: Month/Day/Year for each immunization administered | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Dose #** | **DTP-DTAP** | **Polio** | **HIB** | **Hep B** | **PCV7** | **MMR** | **Varicella** | **Rotavirus** | **MCV4** | **HPV** | **Hep A** | **Other** |
| **1** | | | | | | | | | | | | |
| **2** | | | | | | | | | | | | |
| **3** | | | | | | | | | | | | |
| **4** | | | | | | | | | | | | |
| **5** | | | | | | | | | | | | |

## PART II: MEDICAL INFORMATION (CONTINUED)

**Child's Name** _____

**MEDICAL CONTRAINDICATION:** The above child has a valid medical contraindication to being immunized at this time. This is a permanent temporary condition until ____/____/____. Check appropriate box, indicate vaccine(s) and reasons: _____

_____

**HEALTH PRACTITIONER'S STATEMENT:** To the best of my knowledge, the vaccines listed above were administered as indicated. I conducted a physical examination of the above-named child and find that he/she **IS** / **IS NOT** medically cleared to attend child care.
**(circle correct response)**

| _____ | _____ | _____ |
|---|---|---|
| **Signature of Health Practitioner** | **Date** | **Phone Number** |

**STAMP, PRINT, OR TYPE: Name/address of Physician, Certified Nurse Practitioner, Registered Physician's Assistant.**

## CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. **If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.** The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

| AT RISK AREAS BY ZIP CODE | Baltimore (cont) | Carroll | Frederick(cont) | Montgomery | Prince George's(cont) | St. Mary's |
|---|---|---|---|---|---|---|
| | 21210 | 21155 | 21783 | 20783 | 20782 | 20606 |
| | 21212 | 21757 | 21787 | 20787 | 20783 | 20626 |
| **Allegany** | 21215 | 21776 | 21791 | 20812 | 20784 | 20628 |
| ALL | 21219 | 21787 | 21798 | 20815 | 20785 | 20674 |
| | 21220 | 21791 | | 20816 | 20787 | 20687 |
| **Anne Arundel** | 21221 | | **Garrett** | 20818 | 20788 | |
| 20711 | 21222 | **Cecil** | ALL | 20838 | 20790 | **Talbot** |
| 20714 | 21224 | 21913 | | 20842 | 20791 | 21612 |
| 20764 | 21227 | | **Harford** | 20868 | 20792 | 21654 |
| 20779 | 21228 | **Charles** | 21001 | 20877 | 20799 | 21657 |
| 21060 | 21229 | 20640 | 21010 | 20901 | 20912 | 21665 |
| 21061 | 21234 | 20658 | 21034 | 20910 | 20913 | 21671 |
| 21225 | 21236 | 20662 | 21040 | 20912 | | 21673 |
| 21226 | 21237 | | 21078 | 20913 | **Queen Anne's** | 21676 |
| 21402 | 21239 | **Dorchester** | 21082 | | 21607 | |
| **Baltimore** | 21244 | ALL | 21085 | **Prince George's** | 21617 | **Washington** |
| 21027 | 21250 | | 21130 | 20703 | 21620 | ALL |
| 21052 | 21251 | **Frederick** | 21111 | 20710 | 21623 | |
| 21071 | 21282 | 20842 | 21160 | 20712 | 21628 | **Wicomico** |
| 21082 | 21286 | 21701 | 21161 | 20722 | 21640 | ALL |
| 21085 | | 21703 | | 20731 | 21644 | |
| 21093 | **Baltimore City** | 21704 | **Howard** | 20737 | 21649 | **Worcester** |
| 21111 | ALL | 21716 | 20763 | 20738 | 21651 | ALL |
| 21133 | | 21718 | | 20740 | 21657 | |
| 21155 | **Calvert** | 21719 | **Kent** | 20741 | 21668 | |
| 21161 | 20615 | 21727 | 21610 | 20742 | 21670 | |
| 21204 | 20714 | 21757 | 21620 | 20743 | | |
| 21206 | | 21758 | 21645 | 20746 | **Somerset** | |
| 21207 | **Caroline** | 21762 | 21650 | 20748 | ALL | |
| 21208 | ALL | 21769 | 21651 | 20752 | | |
| 21209 | | 21776 | 21661 | 20770 | | |
| | | 21778 | 21667 | 20781 | | |
| | | 21780 | | | | |


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# NEW CHAPEL CHRISTIAN ACADEMY
# SUMMER PROGRAM PERMISSION SLIP

I, _____, give New Chapel Christian Academy permission for my child, _____, to participate in the NCCA Summer Program for the months of June, July and August 2012. Participation includes all field trips including swimming, water play, and on-site scheduled activities.

I understand and agree that New Chapel Christian Academy will not be held liable for any negligent behavior or misplaced personal items such as ipods, cd players, video games, money, cell-phones, etc.

I understand and agree that if I choose for my child (ren) not to participate in a particular activity; it will be my responsibility to place my choice in writing and submit it to the school office. I understand and agree that if my child does not attend a field trip due to my decision, he or she will be subject to the age group (s) and on-site activities offered. I also understand and agree that the tuition fee will remain the same.

Finally, I understand and agree that if my child (ren) does not attend the program on a given day or for a period of time, I will still be required to pay the programs fees as prescribed at the time of registration.

_____ _____

Parent or Guardian Signature Date

Maryland State Department of Education
School and Community Nutrition Programs Branch

CHILD CARE ENROLLMENT FORM

Name of Child Care Center: **New Chapel Christian Academy**

| Child (ren) | Circle Days in Care | Circle Meals Served |
|---|---|---|
| Name: _____ | M T W TH F | B L PM Snack |
| Name: _____ | M T W TH F | B L PM Snack |
| Name: _____ | M T W TH F | B L PM Snack |
| Name: _____ | M T W TH F | B L PM Snack |

Address of Parent/Guardian: _____

_____

_____

Telephone Number: _____

_____ _____

Printed name of Parent/Guardian Signature

_____

Date Signed

*** Note: This information must be completed every year upon enrollment. If any information should change during the school year or summer program it is the parents responsibility to update the office**.