Bill To #_____
Student #_____

CALVARY Chapel Academy
Where Faith and Learning Soar

2016-2017 VPK COMMITMENT
Viera Campus

ATTACH COPIES OF:
Birth Certificate ____
Immunization Card ____
Physical Exam ____

FOR OFFICE USE ONLY

Date Rec'd _____
Time Rec'd_____
OPTIONAL ACTIVITY FEE $_____
Cash _____ On-Line_____
Check #_____
Staff_____

I. **PERSONAL DATA:**

Student's Name _____
(Last) (First) (Middle)

Male/Female_____ SS Number _____/_____/_____ Date of Birth _____
month/date/year

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Address _____

City _____ State _____ Zip _____ Home Phone: _____

Students Primary E-mail Address: _____

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? ☐ Yes ☐ No

III. **SCHOOL HISTORY:**

List the schools the student has previously attended (name and full address with zip code):
School _____ _____
Address _____ Dates and Grades Attended
_____

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: _____

Please Check the Appropriate Box:
☐ *VPK 4-Day VPK 5-Day* ☐

Activity/Registration Fee for 2016-2017

Program	Days	Time	Activity Fee
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 voluntary.

Tuition Fee for 2016-2017

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. 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 2016-2017 school year. _____**

CALVARY CHAPEL ACADEMY

_____
Tim Flay, Principal

Dr.
Mr.
Ms.
Mrs. _____
Signature of Parent/Guardian

Print Name: _____

_____
Date

_____
Phone No.

Please Indicate:
How did you hear about CCA?

- ☐ Drive By /Sign _____
- ☐ Local Magazine _____
- ☐ Web Site/Facebook
- ☐ Referred by _____
- ☐ CCM
- ☐ Other _____

Bill to Acct #_____
Student Acct #_____

Accounting Verification Form

Date Rec'd_____

For Office Use Only

ATTACH COPIES OF:
Birth Certificate ____
Immunization Card ____
Physical Exam ____

REGISTRATION FEE: $_____
APPLICATION FEE: $_____
TESTING FEE: $_____
Cash _____ On-Line _____
Staff_____ Check _____
Check Amount: _____

Applying for Grade: ☐ **Kindergarten** ☐ **First** ☐ **Second** ☐ **Third** ☐ **Fourth** ☐ **Fifth** ☐ **Sixth** ☐ **Seventh** ☐ **Eight** ☐ **JEDI**

PERSONAL DATA:
Student's Name _____
(Last) (First) (Middle)
Male/Female_____ SS Number _____/_____/_____ Date of Birth _____

Address _____
City _____ State _____ Zip _____ Home Phone: _____
E-mail Address: _____
Father's Full Name: _____ Marital Status: _____
Address _____
City _____ State _____ Zip _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

Mother's Full Name: _____ Marital Status: _____
Address _____
City _____ State _____ Zip _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____

If there are other children in the family, complete the following:
Name: _____ Age/Grade: _____/_____ School: _____
Name: _____ Age/Grade: _____/_____ School: _____
Name: _____ Age/Grade: _____/_____ School: _____

BILLING INFORMATION:

Name of person responsible for this student's tuition and other expenses:
_____
Address _____
City _____ State _____ Zip _____Home Phone: _____

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 _____

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 _____