Enrollment Form 2024-2025

August 19, 2024 – May 16, 2025

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 9-01-24**

____

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 is chosen/listed as an Emergency Contact, a parent must sign & date above line.

List other people allowed to pick up your child from WCA.

Name: **Phone:** **Relationship to student?**

_______________________ _________________ __________________

_______________________ _________________ __________________

_______________________ _________________ __________________

Emergency Code Word ______________________

2024-2025 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 w/Sept 2024 tuition $50 per child due w/Jan 2025 tuition

Monthly Tuition Rates

(Due by 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	_____ $250.00	_____ $240.00	_____ $235.00	
MWF	_____ $385.00	_____ $360.00	_____ $340.00	
M-F	_____ $635.00	_____ $600.00	_____ $575.00	_____ $585.00
Academic School Hours Plus Extended Care Hours: 7:30 am to 5:30 pm				
TTH	_____ $375.00	_____ $355.00	_____ $345.00	
MWF	_____ $535.00	_____ $530.00	_____ $515.00	
M-F	_____ $910.00	_____ $885.00	_____ $860.00	_____ $860.00

NOTE: AUGUST 2023 & MAY 2024 TUITION WILL BE ½ THE REGULAR AMOUNT.

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 the 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 (or designated date), I will be charged a $25 late fee.

_____ I have received the WCA Parent Handbook for the 2024-2025 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 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 private classroom applications (For example: Remind, GroupMe 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

If I cannot be reached to arrange for medical treatment for my child, 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 all liability for any action taken on behalf of my child pursuant to the terms of this medical authorization.

______________________________________ ____
Child's Name Signature of parent or legal guardian Date
(must be signed before notary public)

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 (Prevnar)					
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 [ ]

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