

## 2017-2018 Checklist

1. Registration Form \_\_\_\_\_
2. Registration Application \_\_\_\_\_
3. Signed up to date shot record \_\_\_\_\_
4. Signed discipline policy \_\_\_\_\_
5. Signed health policy \_\_\_\_\_
  
8. Fall Registration Paid (\$300.00)    \_\_\_\_\_ check    \_\_\_\_\_ cash
9. Summer Registration (\$100.00)    \_\_\_\_\_ check    \_\_\_\_\_ cash

**\*\*Your child will not be placed in a class until all of the above are completed.\*\***



**Alpine Christian Academy**

**610 E. Loop 281**

**Longview, Texas 75601**

**Phone: 903-758-4995**

**Fax: 903-757-7603**

**[www.acakids.org](http://www.acakids.org)**

# Fall 2017-2018

Name of child \_\_\_\_\_

Date of birth \_\_\_\_\_ Sex: M F

Child's age: \_\_\_\_\_ by September 1, 2017

Please circle all that apply:

School Days 8:30-2:30	M	T	W	TH	F
Early Birds: 7:15-8:20	M	T	W	TH	F
After School: 2:30-5:30	M	T	W	TH	F

Fall Registration Paid: \$300.00 cash \_\_\_\_\_ check \_\_\_\_\_

# Summer 2017

Child's age: \_\_\_\_\_ by September 1, 2016

Grade Child Completed during the 2016-2017 School Year: \_\_\_\_\_

Please circle all that apply:

School Days 8:30-2:30	T	W	TH
Early Birds: 7:15-8:20	T	W	TH
After School: 2:30-5:30	T	W	TH

Summer Registration Paid: \$100.00 cash \_\_\_\_\_ check \_\_\_\_\_

Field Trip Fee paid (**FOR K-5TH GRADES ONLY**): \$50.00 cash \_\_\_\_\_ check \_\_\_\_\_

Child's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Fathers Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Siblings/Age: \_\_\_\_\_

I hereby authorize ACA to allow my child to leave ONLY with the following persons. Please list name, address, and telephone of each. Children will only be released to a parent or a designated person after verification of ID.

Name #1: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Name #2: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Name #3: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Check ALL that apply:

FIELD TRIPS (Pre-K through Kindergarten): I \_\_\_\_ give OR \_\_\_\_ do not give consent for my child to participate in field trips.

WATER ACTIVITIES (all ages): I \_\_\_\_ give OR \_\_\_\_ do not give consent for my child to participate in water activities (age appropriate).

PUBLISHED PHOTOGRAPHS: I \_\_\_\_ give OR \_\_\_\_ do not give consent for my child's photograph to be used in ads, website, yearbook, Facebook etc.

#### ACA CONTRACTUAL AGREEMENT

1. This agreement is a contract binding both school and parent.
2. This contract may be terminated by the SCHOOL at anytime if the child is unable to adjust or participate in group activities or by the PARENT with a 30 day written notice stating the reason for withdrawal.
3. If any of the above information changes, the parent will inform the ACA office and update this form as needed.

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

\_\_\_\_\_  
Date

SPECIAL NEEDS STATEMENT: (If this does not apply to your child, please write N/A and initial)

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use and any information which caregivers should be aware of:

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

Parent/Guardian Initial: \_\_\_\_\_

**HEALTH REQUIREMENTS**

One of the following must be presented when your child is admitted to ACA or **within one week of admission.**

Please check only one option:

- 1. HEALTH-CARE PROFESSIONAL’S STATEMENT: I have examined the above named child within the past year and find he/she is physically able to take part in the day care program.

\_\_\_\_\_  
Health Care Professional’s signature

\_\_\_\_\_  
Date

OR

- 2. A signed and dated copy of a health care professional’s statement is attached.



**AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:** In the event I cannot be reached to make arrangements for emergency care, I authorize ACA to take my child to: Name of Physician: \_\_\_\_\_

\_\_\_ DCOL 707 Hollybrook 75605 903-757-6042

\_\_\_ Premiere Pediatrics 705 E. Marshall Ave #1002 75601 903-247-7700

\_\_\_ Shining Star 2304 Judson Rd 75601 903-212-6060

\_\_\_ 1st Choice 1205 North 6th St. 75601 903-230-0235

\_\_\_ Other: \_\_\_\_\_

Emergency Medical Care Facility: Please check one

\_\_\_ Longview Regional 2901 N Fourth St, Longview, TX 75605 903-758-1818

\_\_\_ Good Shepherd MC 700 E. Marshall Ave, Longview, TX 75601 903-315-2000

I GIVE CONSENT FOR ACA TO SECURE ANY AND ALL NECESSARY EMERGENCY CARE FOR MY CHILD:

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