



Westminster Pre-Kindergarten Program Application

Child's Full Name _____

Preferred Name _____ Date of Birth _____
(Preferred name you use) (Child must be 4 by August 31st)

Parents' (Guardians') Names _____

Address _____

Home Phone _____ Other Phones _____
(Please indicate work, cell, whose cell, etc.)

E-mail Address _____

May we take photos of your child for bulletin boards, website, newsletters, etc? _____

Parent Agreement

The following items must accompany this completed application:

- ❖ \$50 registration fee
- ❖ Completed student health assessment
- ❖ Completed Pre-school Emergency form
- ❖ Completed automatic withdrawal form with voided check attached

Enrollment Schedule:

- ❖ Siblings of returning students – beginning December 3
- ❖ Members of Redeemer Presbyterian Church – beginning January 15
- ❖ Open Enrollment – beginning February 2

Automatic withdrawals will begin in July and continue through June. \$146.25 will be withdrawn on the 9th of each month. Those wishing to pay in full must remit payment of \$1,755 by August 9th. I agree to pay a late fee, where applicable, of \$20 per late payment.

I understand there is no tuition reimbursement for days missed due to illness or for other reasons.

I will ensure my child is in good health and free of communicable diseases each day he/she participates and will complete the necessary immunizations or required waivers.

I understand it is required that my child be toilet-trained.

Father

Mother

(please turn over)



Statement of Faith

Westminster Christian Academy is a parochial school which teaches the following basic tenets of the historic, orthodox Christian faith.

1. God is a Triune God—Father, Son and Holy Spirit.
2. The Bible is God's infallible and authoritative Word to man. It is the only standard by which faith and practice are to be measured.
3. The chief end of man is to glorify God and enjoy Him forever.
4. Man is created in the image of God. Through his relationship to Adam, man is a sinner by nature and does himself practice sin. He is thus alienated from God, his neighbor, and the world. All have sinned and fall short.
5. Jesus Christ is the only Savior of sinners, the only way to the Father. He died as a substitute for sinners and was raised from the dead so that they might be reconciled to God.
6. Eternal life is a free gift that is received through faith in Jesus alone. Eternal life is neither deserved by anyone, nor can it be earned by good deeds.

I agree with the above statement of faith and commit to personally supporting this school in the educational process and in their teaching of these beliefs to my child.

Father

Mother

Church Membership at: _____



PHYSICIAN'S STUDENT HEALTH ASSESSMENT

Confidential

Statement of Consent:

In order to better serve the health needs of my child, I hereby give my permission for the transfer of health screening records to Westminster Christian Academy and other appropriate health professionals.

Signed: _____ Date: _____

Address: _____

Father/Guardian: _____ street _____ city _____ state _____ zip _____
Work Phone: (____) _____ Home Phone: (____) _____

Name: _____ Birthday: _____ Male/Female: _____

Mother/Guardian: _____ Work Phone: (____) _____ Home Phone: (____) _____

Child lives with: _____ Type of family housing: _____

Physician: _____ Date of last examination: _____

Dentist: _____ Date of last examination: _____

School: _____ Community Services: _____

FAMILY HEALTH HISTORY

Code Comment

1. Are there any chronic illnesses in student's family?
(heart disease, diabetes, cancer, convulsions, mental illness, substance abuse, etc.)

2. Are there any vision defects, hearing losses or spinal deformities in student's family?

Response Codes: M-maternal P-paternal S-sibling N/A-not applicable

CHILD/ADOLESCENT HISTORY

Code Comment

1. Birth weight: _____

2. Any pre-natal or delivery problems? _____

3. Did child walk/talk/develop at usual time? _____

4. Does this child/adolescent:

a. see a health care provider regularly? _____

b. take any medication? _____

c. have a history of any hospitalizations, surgeries or emergency room visits? _____

d. have a history of any childhood disease? _____

e. have a history of other communicable diseases? _____

f. have a history of menstrual problems?
Age of menarche: _____

g. have a history of vision, speech, hearing or communication problems? _____

h. have a problem with being tired or overactive? _____

i. have any emotional or behavioral problems? _____

j. need any special help in school or daycare? _____

Response codes: Y-Yes N-No N/A-Not applicable

k. have any chronic illness or disabling problems with: *(circle those that apply)*

headache convulsions diabetes earaches heart/lung rheumatic fever genitalia colds
oral/dental extremities back/spine allergies/asthma urinary/bowel digestive other

Please explain:

List any present concerns:

(please turn over to continue)

PHYSICAL EXAMINATION

(to be completed by health care provider approved to perform health assessments)

Height _____ Weight _____ Pulse _____ Blood Pressure _____
 Lead _____ Urinalysis _____ Sickle Cell _____ Tuberculosis _____
 Head Circumference _____ Other _____

	Code	Comment
General Appearance	_____	_____
Integument	_____	_____
Head/Neck	_____	_____
EENT	_____	_____
Oral/Dental	_____	_____
Thorax	_____	_____
Breasts	_____	_____
Cardiovascular	_____	_____
Abdomen	_____	_____
Muscular/skeletal	_____	_____
Genito-urinary	_____	_____
Neurological	_____	_____

Code: o - no significant findings X - significant findings

SCREENING

- Nutritional Evaluation (all ages, each screen)
 - Food Intake Review results:
 - milk/milk products: _____
 - fruit/vegetables: _____
 - meat/beans/eggs: _____
 - bread/cereals: _____
- Development: type of screen: _____ Results: _____
- Speech: type of screen: _____ Results: _____
- Hearing: type of screen: _____ Results: _____
- Vision: type of screen: _____ Results: _____

Anticipatory Guidance: (circle those discussed)

Safety/poisons	Dental	Nutrition	Development	Parenting
Behavior	Discipline	Hygiene	Immunizations	Other: _____

Comments: _____

Significant Assessment Findings: _____

Recommendations: (include referrals)

Follow Up:
IMMUNIZATION: (record date of each dose received: mm/dd/yy)

REQUIRED VACCINES					NOT REQUIRED BUT RECOMMENDED				
VACCINE	1 st	2 nd	3 rd	4 th	5 th	VACCINE	1 st	2 nd	3 rd
DTP, DtaP and/or DT/Td						HEP B (Hepatitis B Vaccine)			
OPV or IPV (Polio)						HEP A (Hepatitis A Vaccine)			
MMR (Measles, Rubella and Mumps combined)						HIB (Haemophilus Type B)			
						Varicella (Chicken Pox)			

Signature: _____ Date: _____

Licensed Physician or Nurse approved to perform health assessments
 ADDITIONAL MATERIAL MAY BE ATTACHED



WESTMINSTER CHRISTIAN ACADEMY PRE-SCHOOL EMERGENCY FORM

DATE: _____

LAST NAME _____ HOME PHONE: _____

Child's Name: _____ (Pre-School)

Please list phone numbers in the sequence we should call.

<u>Number</u>	<u>Phone Type</u> (work/home/cell/pager)	<u>Whose phone?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**IF ANY OF THIS INFORMATION CHANGES DURING THE YEAR,
PLEASE CONTACT THE SCHOOL OFFICE.**

If my child needs emergency medical care, I prefer treatment at: _____
if possible. *Name of preferred hospital*

Medical Insurance with: _____

Policy Number: _____

Group Number: _____

Child's Primary Care Physician: _____
Name *Office Number*

Briefly summarize any health issues or allergies that medical personnel should be aware of in an emergency:

