ConcordiaChurch
&School Here ... you're home!

1695 Discovery Falls Drive
Chula Vista. California 91915
619 656 8100 tel
619 656 8108 fax
www.concordiachurch.com

BEFORE AND AFTER SCHOOL PROGRAM

RE-ENROLLMENT PACKET

This packet should be completed only if you are re-enrolling your child for the Before and After School Program. If you are new to the program, please go back to the website and download the Before and After School Program Enrollment Packet.

State Requirements for Re-enrollment

License #376701235

Check that all forms are completed and signed.

Completed	Description
	Application
	Electronic Payment Authorization
	Identification and Emergency Information (LIC 700)
	Consent for Emergency Medical Treatment (LIC 627)
	Classroom Emergency Information
	Medical History
	Parents' Contract for Admission of Students

Child's Name Date

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BEFORE/AFTER SCHOOL PROGRAM APPLICATION

License #376701235

Student Information

Child's Last Name	Child's First Name	Date of Birth (mm/dd/yyyy)
Child's Address		
City	State	Zip
Referred By		

Parent / Legal Guardian 1

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Cell Phone Number	Home Phone Number	Email Address
Employer		Work Phone Number

Parent / Legal Guardian 2

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Cell Phone Number	Home Phone Number	Email Address
Employer		Work Phone Number

There is no application fee for re-enrolling your child.

Prices effective August 1, 2019

Select Program Option	Program Days	Program Weekly Cost
☐ Before and After School	Monday through Friday	$130.00
☐ Before School Only	Monday through Friday	$96.00
☐ After School Only	Monday through Friday	$115.00

The following information will help us better serve you and your family.

Family Information

Are you a military family? ☐ Yes ☐ No	Any immediate deployments pending? ☐ Yes ☐ No
Dad deployment dates	Mom deployment dates
Do you regularly attend a local church? ☐ Yes ☐ No Name of Pastor:	Is your child baptized? ☐ Yes ☐ No Would you like more information on baptism? ☐ Yes ☐ No

After completing the registration packet, return it and the fee to the School Office in person.

Thank you.

Aaron Partch and Michelle Schmidt, Directors

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ELECTRONIC PAYMENT AUTHORIZATION

FOR OFFICE USE ONLY

Date	Child Number	Child Name

☐ Preschool and Child Care Center	☐ Before and After School Program	☐ Intersession Program

Effective date of authorization (mm/dd/yyyy)

Type of authorization (check all that apply)

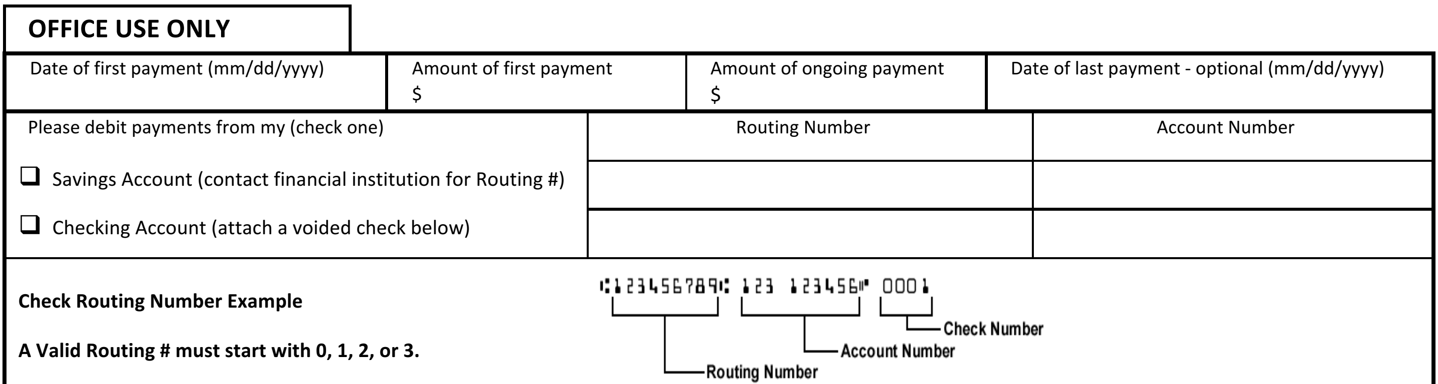
❑ New authorization ❑ Change payment amount ❑ Change payment date ❑ Change banking information ❑ Discontinue payment

Last Name	First Name

Address

City	State	Zip

Primary Phone	Email



OFFICE USE ONLY

Date of first payment (mm/dd/yyyy)	Amount of first payment $	Amount of ongoing payment $	Date of last payment - optional (mm/dd/yyyy)

Please debit payments from my (check one)	Routing Number	Account Number
❑ Savings Account (contact financial institution for Routing #)		
❑ Checking Account (attach a voided check below)		

Check Routing Number Example

A Valid Routing # must start with 0, 1, 2, or 3.

Monthly payment will be deducted on the 3rd.

I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature	Date

Please attach a voided check at the bottom of this page.

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST MIDDLE FIRST | SEX | TELEPHONE ( )

ADDRESS NUMBER STREET CITY STATE ZIP | BIRTHDATE

FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST MIDDLE FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER STREET CITY STATE ZIP | HOME TELEPHONE ( )

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST MIDDLE FIRST | BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER STREET CITY STATE ZIP | HOME TELEPHONE ( )

PERSON RESPONSIBLE FOR CHILD LAST NAME MIDDLE FIRST | HOME TELEPHONE ( ) | BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( )

DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: ______________________

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE | DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION | DATE LEFT

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Concordia Preschool and Child Care
FACILITY NAME
TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

______________________________ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

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Before and After School Classroom Emergency Information

Student Information Today's Date:

Child's Last Name	Child's First Name	Date of Birth (mm/dd/yyyy)	Age
Does your child take any medication on a regular basis? ☐ Yes ☐ No If yes, please list medication.			
List any allergies or special needs your child has.			
Is there anything else we should know about child?			

Father / Legal Guardian 1

Last Name	First Name	Middle Initial	
Address	City	State	Zip
Cell Phone Number	Home Phone Number	Email Address	
Employer/Occupation		Work Phone Number	

Mother / Legal Guardian 2

Last Name	First Name	Middle Initial	
Address	City	State	Zip
Cell Phone Number	Home Phone Number	Email Address	
Employer/Occupation		Work Phone Number	

All People Who Are Authorized to Pick Up Other than Parents

Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship

Photo Release (check all that apply)

I give permission to use my child's photo for the following purpose:

☐ Promotional Materials ☐ Classroom Use (art projects, to hang in the classroom and the hall) ☐ None at this time

Official use only.

Classroom: ___________________________________

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Medical History

Child Information

Last Name	First Name	Date

Parent / Legal Guardian 1

Last Name	First Name	
Cell Phone Number	Home Phone Number	Work Phone Number

Parent / Legal Guardian 2

Last Name	First Name	
Cell Phone Number	Home Phone Number	Work Phone Number

Medical History

Please list your child's medical history including hernias, head injuries, heart disorders, cancer, arthritis, scoliosis, hearing/vision problems, learning difficulties, eating disorders, or other illnesses.
If pre-existing medical conditions may affect participation in daily activities, please have your doctor document these conditions and give approval or agree to discuss the condition with a Concordia School Director.

Parent/Legal Guardian Signature

Sign Full Name	Print Full Name	Date

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CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM
PARENTS' CONTRACT FOR ADMISSION OF STUDENTS

License #376701235

Parents/Legal Guardians with whom student lives

Father/Legal Guardian Last Name	Father/Legal Guardian First Name	Cell Phone	
Mother/Legal Guardian Last Name	Mother/Legal Guardian First Name	Cell Phone	
Address	City	State	Zip

Student Information

Child's Last Name	Child's First Name	Middle Initial	Date of Birth
By my signature on this document, I acknowledge that I am the parent or legal guardian of the above student for whom I have requested admission into the Before and After School Program.			

Note: In addition to this contract, the application fee and tuition for the first week are due one week before your child's first day of school. **These fees are nonrefundable.**

BY RESOLUTION OF THE BOARD OF EDUCATION FOR THE BEFORE AND AFTER SCHOOL PROGRAM (B/A), THE FOLLOWING STATEMENTS ARE DESIGNED TO BE THE CONDITIONS FOR ADMISSION:

In consideration of such admission, I agree to the conditions governing admission and attendance at the B/A, as stated below:

1. I agree to pay tuition charges and fees established by the administration for the current year.
2. I understand that only one discount per qualifying family may be applied to my child's tuition rate.
3. I agree to make tuition and fee payments to the B/A on or before the scheduled dates. I acknowledge that the B/A may enforce the following penalty: **The B/A may, at its sole option, terminate the enrollment of any student when payment of fees is in arrears and has not been received by the B/A within 30 days unless prior arrangements have been made with the Business Administrator. Termination may also be due to parents displaying and demonstrating aggressive behaviors to the staff, and if the safety/health of other children is being threatened by a child.**
4. I also agree to:
   a. Read and adhere to the rules and regulations set forth in the Parent Handbook. I also understand and agree that bulletins containing new and revised rules and regulations issued to me carry the same weight as the Parent Handbook**. Violations of the stated rules and regulations may result in expulsion from the B/A.**
   b. Allow my child to participate in all school functions, including those that are worship related.
   c. Give TWO (2) WEEKS WRITTEN NOTICE if my child will be leaving. If written notice is not given, I agree to pay for those two weeks.

Tuition is due and payable on the 3rd of the month by automatic electronic withdrawal from a checking or savings account. **A $25.00 nonsufficient funds fee will be assessed for each payment not honored by the bank.**

Please note: Before and after school care is available from 6:30 am to 6:30 pm. Children picked up after 6:30 pm will be charged **a late fee of $1.00 per child, per minute or fraction thereof and thereafter**. ***After three (3) late pick-ups per quarter, the child may be put on probation pending a review of the circumstances. Abuse of this may cause the child to be expelled from the program.***

1. **APPLICATION** – This fee applies to every student enrolled. It is **NONREFUNDABLE** in the event the student does not attend the B/A or terminates attendance for any reason and does not apply to any portion of the fee.
2. **RATE CHANGE** – The administration reserves the right to adjust the prices of its programs at the beginning of each academic school year (mid-July); families will be informed of this change as students enroll for the upcoming school year.
3. **REFUNDS** – Upon a two-week notice by the parent **"BEYOND THE FIRST MONTH,"** a refund will be pro-rated for the time not used based upon the program the family enrolled under.
4. **RIGHTS OF CHILD CARE LICENSING:**
   a. The Department has inspection authority to enter and inspect a facility without advance notice.
   b. The Department has the authority to interview children or staff, and to inspect and audit child or Child Care Center records without prior consent.

I UNDERSTAND THAT THE DEPARTMENT OF SOCIAL SERVIES OR LICENSING AGENCY HAS THE AUTHORITY TO OBSERVE, INTERVIEW, AND HAVE MY CHILD(REN) PHYSICALLY EXAMINED AT ANY TIME WITHOUT PRIOR CONSENT. AUTHORITY CITED: SECTION 1596.81, HEALTH & SAFETY CODE.

THE LICENSEE SHALL MAKE PROVISIONS FOR PRIVATE INTERVIEWS WITH ANY CHILD(REN) OR ANY STAFF MEMBER AND FOR THE EXAMINATION OF ALL RECORDS RELATING TO THE OPERATION OF THE FACILITY.

THE DEPARTMENT OF LICENSING AGENCY SHALL HAVE THE AUTHORITY TO OBSERVE THE PHYSICAL CONDITION OF MY CHILD(REN), INCLUDING CONDITIONS WHICH COULD INDICATE ABUSE, NEGLECT OR INAPPROPRIATE PLACEMENT AND TO HAVE A LICENSED MEDICAL PROFESSIONAL PHYSICALLY EXAMINE MY CHILD(REN).

SUMMARY- I agree to pay the tuition, fees, and charges scheduled herein on or before the due date and to abide by the terms and conditions of the Parent's Contract for Admission of Students***. I UNDERSTAND THAT I MUST GIVE A TWO-WEEK WRITTEN NOTICE WHEN WITHDRAWING MY CHILD.*** In addition, I fully understand and abide by the conditions and terms of this contract.

Father/Legal Guardian Signature

Sign Full Name	Print Full Name	Date

Mother/Legal Guardian Signature

Sign Full Name	Print Full Name	Date