

WELCOME TO CORAL PARK CHRISTIAN ACADEMY
Passion for Learning, Passion for God.



CHRISTIAN ACADEMY

**ENROLLMENT
PACKET
2023-2024**

**ELEMENTARY /
MIDDLE SPED**

ENROLLMENT PACKET 2023-2024

ELEMENTARY/MIDDLE/FES UA TUITION AND FEES



CHRISTIAN ACADEMY
8755 SW 16th ST.
Miami, FL 33165
305.559.9409

ENROLLMENT FEE: (Non-Refundable): \$550.00 Per Student.

FES-UA

SPED ANNUAL TUITION <i>Tuition in 11 Payments Available (July - May)</i>	
Kindergarten SPED	\$7,600.00
1st - 4th Grade SPED	\$7,910.00
5th Grade SPED	\$8,220.00
6th - 8th Grade SPED	\$8,630.00

SPED ANNUAL FEES	
Kindergarten	\$1,650.00
1st - 4th Grade	\$1,790.00
5th Grade	\$1,890.00
6th - 8th Grade.....	\$1,970.00
Kinder Graduation	\$250.00
5th and 8th Grade Graduation	\$300.00

All fees are non-refundable. All fees must be honored by due date to secure your child's placement.

TUITION DISCOUNTS AVAILABLE	
Full Tuition Payment (Due August 1st)	5%
Semester Payment (Due Aug. 1st & Jan. 2nd)	3%
Sibling Discount	10%
Second Sibling Discount.....	15%
Third Sibling Discount	20%
U.S Active Military/Veteran (Only Once).....	10%
Church Member Discount	10%
Family Referral Credit (Only once, tuition).....	\$200.00

Combination of discounts will not be offered (more info at main office).

OTHER FEES AND SERVICES	
Entrance Exam Fee (Non-Refundable).....	\$130.00
Tutoring Services (per quarter)	2,000.00
NSF/Returned Check Fee.....	\$40.00
Late Payment Fee.....	\$40.00
Meal Plan	\$160.00
Meal Plan (Aug., Dec., March only)	\$120.00
Meal plan (If ordered daily).....	\$9.00
Late Pick Up Fee	\$1.00 per min.

Late pick up fees apply to all programs after 12:01 noon (early release), 3:15pm, 6:01pm (Fee will be paid separate in cash or check)

BEFORE & AFTER CARE FEES	
After Care Service (Monthly).....	\$180.00
After Care Service (Aug., Nov., Dec., and March Only)...	\$100.00
Monthly Morning Care (Only).....	\$75.00
Before or After care (1 Day Only).....	\$15.00

SCHOOL HOURS FOR 2023-2024	
Kindergarten	8:00am - 2:45pm
1st - 8th grade	8:00am - 3:00pm
Before Care (Morning)	7:00am - 7:59pm
After Care (Afternoon)	3:15am - 6:00pm

VOLUNTARY WITHDRAWALS: Students attending school for any part of the month are responsible for the full payment of that month.

* Visa and MasterCard payments accepted. A convenience fee of \$4.00 will apply. Transactions above \$1000.00 a 2% fee will apply.

PARENT / SPONSOR ACKNOWLEDGMENT

The above fees were reviewed on (Date): _____ Staff Initials: _____

Print Name: _____ Signature: _____

*My signature above indicates that I reviewed the aforementioned, fully understand my financial obligations to Coral Park Christian Academy and my willingness to fully cooperate and adhere to for the 2023-2024 academic year and its Handbook
For your convenience, we accept Visa and MasterCard payments. A convenience fee of \$4.00 will be added to each transaction.

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I. IMPORTANT FINANCIAL POLICIES AND OTHER INSTRUCTIONS (Part 1):

- Each new student is admitted on a probationary basis. If the student is making acceptable progress and adjusting to the school by the end of the first quarter (nine-week period), the probation will be lifted. If the adjustment is not satisfactory, the probationary period may be extended, or the student may be reassigned to their previous grade or withdrawn.
- **To all Coral Park Christian Academy students: One of the following conditions must be present for a parent to be asked to withdraw their child from the program:**
 1. The child/student's behavior is harmful or upsetting to other children/student's in the program.
 2. CPCA is unable to meet the individual needs of the child/student.
 3. The child/student's behavior is disruptive to the point of preventing other children from learning.
- All re-admission decisions are based upon the following: 1) the student's academic progress and preparation to successfully perform at the grade level he/she is entering, 2) the student's record of conduct and behavior, as well as, our assessment of his/her ability and desire to be a constructive and positive influence within the school community, 3) the parents'/guardians' past year's full cooperation with the school administration and positive attitude about attending CPCA, 4) Parents/guardians and student(s) must have demonstrated a commitment to cooperate in the spiritual, academic, and social life of the school in the previous school year, 5) Parents/Guardians have met all financial responsibilities to CPCA, in a timely basis.
- Returned checks are **NOT** re-deposited and a \$40.00 service charge will be assessed. Your account will be placed on a cash basis **if a second check** is returned. All Checks are payable to **Coral Park Christian Academy**.
- If you withdraw your student, you are financially responsible for the balance owed. Students attending **part of a month** are responsible for the full payment of that month regardless of the withdrawal date. **If Voluntary Withdrawal occurs, fees of any kind are non-refundable.**
- **Coral Park Christian Academy** follows the same closing procedures as the Miami Dade County Public School System in the event of a natural disaster or any other emergency.
- **Coral Park Christian Academy** reserves the right to withhold Report Cards, School Records, grades and/or diplomas due to outstanding account balances. Once account has been cleared, grades and/or diplomas will be released and sent to the mailing address indicated on your child's application.

Print Name: _____

Parent/Guardian Signature: _____ Date: _____

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I. IMPORTANT FINANCIAL POLICIES AND OTHER INSTRUCTIONS (Part 2):

FEE POLICY (To be completed by staff; reviewed and initialed by the parent/guardian/sponsor after completion)

Initials

- Tuition is due and payable on the first business day of the week, **MONDAY**. _____
- Tuition for school and after school must be paid regardless of holidays (this includes Winter and Spring breaks), emergency closures (i.e., weather), sickness and vacation will not be credited. Only absence due to hospitalization, hospital paperwork must be turned in upon arrival back to the center. (**Only hospital paperwork** will be permitted to receive credit). This is NOT for urgent care visits. _____
- I agree to pay the full tuition and selected services in advance of services rendered. _____
- I agree to pay the full tuition fee even if my child is absent for one or more days. _____
- A late fee of **\$40.00** is due if tuition is not received by **Tuesday at noon**. _____
- A non-refundable registration/material fee is due yearly. _____
- A late pick-up fee of **\$5.00 for the first minute and \$1.00** per minute after that per child, this also includes late pick up for students that are released at 12:00pm, 3:15pm and 6:01pm. _____
- Accounts two weeks in arrears may result in immediate termination of service. _____
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip will be required. Account must be current in order to participate. _____
- All returned checks or ACH transactions (automatic debits) will be charged a fee of \$35.00. Two returned checks or ACH transactions will result in my account being placed on "money order or cash only" status. _____
- A receipt for Income Tax purposes will be provided. Account **MUST** be current. Balance must be \$0.00. _____

UNIFORM POLICY ACKNOWLEDGEMENT PARENT SIGNATURE:

All Students must wear the CPCA School Uniform with no exceptions. _____

- **1st Violation:** Parent will be sent a note home requiring signature.
- **2nd Violation:** Parent will be called and asked to bring correct uniform.
- **3rd Violation:** Student will be sent home.

Print Name: _____

Parent/Guardian Signature: _____ Date: _____

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2. STUDENT/PARENT GENERAL INFORMATION (PART 2)

PARENT'S SPOUSE (Living at the above address)

Title: Mr. Mrs. Ms. Dr. Rev.

Parent's Last Name

First Name

Middle

Relationship to the Student: Mother Father Guardian

Bill this Parent: Yes No

Address

City

State

Zip Code

Occupation: _____ Employer's Name: _____

Home/Cell Phone: _____ Work Phone: _____

Social Security (Last 4 #): _____ Church Parent Attends: _____

Email (Required): _____

PARENT (Not living with the student)

Title: Mr. Mrs. Ms. Dr. Rev.

Parent's Last Name

First Name

Middle

Relationship to the Student: Mother Father Guardian

Bill this Parent: Yes No

Address

City

State

Zip Code

Occupation: _____ Employer's Name: _____

Home/Cell Phone: _____ Work Phone: _____

Social Security (Last 4 #): _____ Church Parent Attends: _____

Email (Required): _____

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3. OTHER STUDENT INFORMATION

PHOTOS FOR THE SCHOOL/WEBSITE

I give permission for my child, _____
To participate in photos taken for the school and to upload to the school web site,

Yes, I Agree No, I Do Not Agree

Parent's Signature

Date

Coral Park Christian Academy is a ministry of First Baptist Church of Coral Park. Our school will emphasize the worth of the individual and the eternal values of God as well as provide an environment of academic excellence.

Coral Park Christian Academy admits students of any race, color, nationality and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school.

Coral Park Christian Academy does not discriminate based on race, color, nationality and ethnic origin in administration of its educational policies, admissions policies, scholarships, loan programs, athletic and other school-administered programs.

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4. Medical Information (All records are confidential, Part 1)

STUDENT'S MEDICAL CARE PROVIDER			
Primary physician's name:	Primary physician's practice name:	Phone:	
Physician's practice address:	City:	State:	Zip:
Preferred hospital/clinic for emergency care:	City:	State:	
Dentist's name:	Dentist's practice name:	Phone:	
Dentist's practice address:	City:	State:	Zip:
Does the student have a documented disability? Yes No (if yes check all that apply-Parent MUST provide Doctor's Documentation and/or IEP)			
<input type="checkbox"/> Individualized Family Service Plan (IFSP; if under 3-years-old) <input type="checkbox"/> Individualized Education Plan (IEP) from the school system <input type="checkbox"/> Disclosed by the parent or guardian describing the child's specific condition <input type="checkbox"/> Diagnosis by a State certified/licensed professional (ex., psychologist) <input type="checkbox"/> Section 504 Plan <input type="checkbox"/> Medical diagnosis from a doctor <input type="checkbox"/> Autism Spectrum Disorders <input type="checkbox"/> Chronic Medical Condition <input type="checkbox"/> Developmental Delay (under 5 only) <input type="checkbox"/> Emotional and/or Behavior Disorder <input type="checkbox"/> Learning Disability <input type="checkbox"/> Behaviors (ADHD/other: _____) <input type="checkbox"/> Hearing Impaired (or deaf) <input type="checkbox"/> Intellectual Disability (or Mental retardation) <input type="checkbox"/> Speech/Language Impairment <input type="checkbox"/> Visual Impairment (or Blind) <input type="checkbox"/> Other Disability: _____ <input type="checkbox"/> Physical Disability			
STUDENT'S INSURANCE PROVIDER:			
Student's Health Insurance Provider Name: _____		Policy Number: _____	
Secondary Health Insurance Provider Name: _____		Policy number: _____	
STUDENT'S IMMUNIZATION HISTORY (Please attach a copy of your child's immunization records)			
Additional Medical Policies: _____		Signature: _____	
<p>1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state childcare regulations.</p> <p>2. I agree to provide information to the school about my child's conditions, illnesses, allergies or other needs.</p> <p>3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.</p> <p>4. If my child becomes ill during his/her time at the school, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 1 hour after being contacted. If I cannot be reached, the staff will contact those listed in the Child Emergency Contact and Release.</p> <p>5. If your child is sick and has had fever, vomiting, diarrhea or show evidence of communicable disease; please make arrangements for alternative care. If your child has such symptoms and is present at you will be asked to pick up your child within the hour.</p> <p>6. No medication shall be given by CPCA personnel. Contact our office in case of emergency.</p>			
EMERGENCY MEDICAL AUTHORIZATION & CONSENT			
SIGNATURE: _____			
In case of a medical emergency, the staff will attempt to contact me, those listed in the Child Emergency Contact and Release, and lastly my physician.			
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.			
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.			
In case of a medical emergency, I will be responsible for the emergency medical expenses.			
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center			
Doctor's Name: _____			
Doctor's Phone Number: _____			

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4. Medical Information (All records are confidential, Part 2)

Student's Medical and Developmental History (If Yes, please attach plan of care instructions from your physician)

1. Does your child have any special medical conditions? No Yes
2. Does your child have any chronic illnesses? No Yes
3. Please attach list of any history of your child's serious injuries and hospitalizations.
4. Does your child have diabetes? No Yes
5. Does your child have asthma? No Yes
6. Will medication be administered regularly?: No Yes
7. Does your child have any special dietary needs? No Yes
8. Is your child able to fully participate in all activities? No Yes
9. Does your child have any physical restrictions? No Yes
10. Does your child function at the level of other children in his/her age group? No Yes
11. Is your child able to walk o Yes oNo oN/A Infant
12. Can your child communicate his/her needs? No Yes oN/A Infant
13. Does your child need assistance at mealtime? No Yes oN/A Infant
14. Does your child use any special equipment, such as breathing machine, wheelchair, hearing aid, braces, glasses etc.? No Yes
15. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? No Yes

ILLNESS HISTORY (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Asthma/breathing problems | <input type="checkbox"/> Urinary track infectios | <input type="checkbox"/> Other |

Please attach care instructions from your physician for any of these illnesses

DISEASE HISTORY (Please check all that apply and add the date)

- | | | |
|---|---|--|
| <input type="checkbox"/> Chicken Pox(Varicella) _____ | <input type="checkbox"/> Bronchiolitis _____ | <input type="checkbox"/> Botulism _____ |
| <input type="checkbox"/> Measles Rubeola _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Hemophilus Influenza _____ |
| <input type="checkbox"/> Rubella (German Measles) _____ | <input type="checkbox"/> Pertussis (Whooping cough) _____ | <input type="checkbox"/> Meningococcal Infection _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Tetanus _____ | <input type="checkbox"/> Rabies _____ |
| <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Diphtheria _____ | <input type="checkbox"/> Bacterial Meningitis _____ |

ALLERGIES (Please list)

- | | | | |
|-----------------------|----------|--|--|
| Medication Allergies | Reaction | Food Allergies | Reaction |
| Insect Bite Allergies | Reaction | Respiratory Allergies, | Reaction |
| Other Allergies | Reaction | Are any of these allergies life-threatening? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please attach care instructions from your physician for any life-threatening allergies...

MISCELLANEOUS SCREENINGS AND TESTS (Please check all that apply and add the date of last screening)

- | | | |
|--|--|---|
| <input type="checkbox"/> Vision _____ | <input type="checkbox"/> Developmental _____ | <input type="checkbox"/> Tuberculosis (PPD) _____ |
| <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Aptitude _____ | <input type="checkbox"/> Sickle Cell Anemia _____ |
| <input type="checkbox"/> Speech _____ | <input type="checkbox"/> Educational _____ | <input type="checkbox"/> Other _____ |

To the best of my knowledge the information contained above is accurate.

Parent initial: _____ Staff initial: _____

Date: _____

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5. STATEMENT OF COOPERATION

The rules and guidelines, as set forth in our Parent/Student Handbook, are taken seriously by the CPCA administration and staff. It is not necessary that a student or parent agree with every rule and policy the school endorses. It is expected, however, that the parents and the students cooperate with the policies if the student is enrolled at Coral Park Christian Academy. In submitting an application for my child, I give permission for my child to participate in all school activities, including sports and school-sponsored trips away from the premises understanding that every reasonable care will be extended to my child during school hours, activities, and events. I agree to hold the school harmless for any liability in the event my child is accidentally injured during school hours and events. If I do seek legal recourse against Coral Park Christian Academy and the school is found to be NOT at fault, I agree to pay any attorney's fees, or other costs that CPCA or its agent should incur to defend itself against such action.

I, the undersigned acknowledge that I have read and agree to cooperate with the policies stated in the Parent/Student Handbook.

Each student in the family in grades 6 through 8 must sign:

1.	_____	_____
	Student's Name	Student's Signature

	Date	
2.	_____	_____
	Student's Name	Student's Signature

	Date	
3.	_____	_____
	Name of Parent or Legal Guardian	Signature of Parent or Legal Guardian:

	Date	

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ELEMENTARY/MIDDLE SPED EMERGENCY CONTACT FORM



CHRISTIAN ACADEMY

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6. FAMILY INFORMATION

Last Name: _____	First Name: _____	Middle: _____
Relationship to child: _____	Social Security # (last 4): _____	
Street Address: _____	City: _____	State _____ Zip Code: _____
Home Phone: _____	Work Phone: _____	
Cell Phone: _____	Email: _____	

Last Name: _____	First Name: _____	Middle: _____
Relationship to child: _____	Social Security # (last 4): _____	
Street Address: _____	City: _____	State _____ Zip Code: _____
Home Phone: _____	Work Phone: _____	
Cell Phone: _____	Email: _____	

7. CHILD INFORMATION

Last Name: _____	First Name: _____	Middle: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SS # (last 4): _____	DOB: _____
Emergency Contact: _____	Phone #: _____	
Authorized Pick Up Person: _____	Phone #: _____	
Authorized Pick Up Person: _____	Phone #: _____	
Authorized Pick Up Person: _____	Phone #: _____	
Known Allergies: _____	Date: _____ / _____ / _____	

Last Name: _____	First Name: _____	Middle: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SS # (last 4): _____	DOB: _____
Emergency Contact: _____	Phone #: _____	
Authorized Pick Up Person: _____	Phone #: _____	
Authorized Pick Up Person: _____	Phone #: _____	
Authorized Pick Up Person: _____	Phone #: _____	
Known Allergies: _____	Date: _____ / _____ / _____	

8. EMERGENCY CARE AUTHORIZATION

I certify that I am a parent or legal guardian of the child or children named above and give consent for emergency medical care, surgical treatment, and/or transportation to a care facility should my child's condition require it in my absence. I understand that, time and conditions permitting, reasonable attempts will first be made to contact me and any designated representatives in such a case. I hereby assume all financial responsibility for such actions taken on behalf of my child.

Signature of Parent or Legal Guardian: _____ Date _____

OFFICE USE ONLY		
Tuition: \$ _____	Classroom: _____	Enrolled: _____
Billing cycle: _____	Program: _____	Enrolled by: _____

RESET

PRINT