

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



CHRISTIAN ACADEMY

**ENROLLMENT
PACKET
2024-2025**

PRE-SCHOOL

**Fill, Sign and Send Form by Mail to:
mainoffice@coralparkchristian.org**

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL TUITION AND FEES



ENROLLMENT FEE: (Non-Refundable): \$390.00 Per Student / \$230.00 (VPK + 3hrs.)

| MONTHLY TUITION: <i>Tuition in 11 payments available (July - May)</i> | |
|---|----------|
| Infant (0-12 months) | \$600.00 |
| 1 Year Old | \$670.00 |
| 2 & 3 Years old | \$700.00 |
| VPK Program (3hrs. Only) | FREE |
| VPK (Voucher + 3hrs.) | FREE |
| VPK No Voucher | \$600.00 |

| TUITION DISCOUNTS AVAILABLE | |
|---|----------|
| Sibling Discount | 10% |
| Second Sibling Discount | 15% |
| Third Sibling Discount | 20% |
| U.S. Active Military/Veteran | 10% |
| Church Member Discount | 10% |
| Family Referral Credit (Only once, tuition) | \$400.00 |
| \$250 for the referring party & \$150 for the new family. | |

| ANNUAL FEES | |
|--|----------|
| Infant - 1 Year Old | \$775.00 |
| 2 & 3 Years Old | \$925.00 |
| VPK (3hrs. Only) | FREE |
| VPK (Voucher + 3hrs.) | \$775.00 |
| VPK (No Voucher) | \$800.00 |
| Graduation (All VPK Due April 4th) | \$130.00 |

*All fees are non-refundable. Fees must be honored by due date to secure your child's placement.
Combination of discounts will not be offered (more info at main office).*

| OTHER FEES AND SERVICES | |
|-----------------------------------|----------|
| Infant - VPK (PT 8-12pm) | \$500.00 |
| NSF/Returned Check Fee | \$40.00 |
| Late Payment Fee | \$40.00 |
| VPK Extended Service | \$300.00 |
| VPK (Non Instructional Day) | \$50.00 |
| VPK Weekly Care (Breaks) | \$200.00 |

*School Readiness Gap Fee, (0-4 years old applies).
Late pick up fees apply to all programs after 12:01 noon, early release 3:01pm, 6:01pm.
(Fee will be paid separate in cash or check)*

| SCHOOL HOURS FOR 2023-2024 | |
|-----------------------------------|------------------|
| Infant - PreK3 | 7:00am - 6:00pm |
| VPK (Voucher) | 8:30am - 11:30am |
| VPK (Voucher + 3hrs Free) | 8:30am - 2:30pm |
| VPK Morning Care | 7:00am - 8:29am |
| VPK After Care | 2:31pm - 6:00pm |

*Pre-School Admission: Children must be 1 year old and walking to be enrolled in the One Year Program.
Must be also fully potty-trained to be enrolled in K3-VPK Program.*

** 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

he 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 2024-2025 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.

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL



1. IMPORTANT FINANCIAL POLICIES AND OTHER INSTRUCTIONS:

- Pre-School accounts are entitled to one full week of vacation with previous approval. A 25% discount will be applied accordingly. If illness occurs a % discount will also be applied ONLY with proper doctor notice. *Be aware that Illness credit will be offered for one (1) week maximum. In case of extended illness (Maximum an extra week) credit will be offered ONLY with hospitalization paperwork at a discretionary discount.* After you have reached the maximum of all weeks allowed (2 weeks) accounts will be billed in full.
- 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.
- **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.

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. | _____ |
| • Families facing financial difficulties can contact us via email to request assistance. We will collaborate with their guardians/parents to provide support to the best of our possibilities. | _____ |
| • 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 12:01pm, 3:01pm and 6:01pm. | _____ |
| • Accounts one months 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. <u>Account must be current in order to participate.</u> | _____ |
| • All returned checks or ACH transactions (automatic debits) will be charged a fee of \$40.00. Two returned checks or ACH transactions will result in my account being place on "money order or cash only" status. | _____ |
| • A receipt for Income Tax purposes will be provided. <u>Account MUST be current. Balance must be \$0.00.</u> | _____ |

UNIFORM POLICY ACKNOWLEDGEMENT PARENT SIGNATURE:

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

Print Name: _____

Parent/Guardian Signature: _____ Date: _____



STATE OF FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CHILD CARE APPLICATION FOR ENROLLMENT

I. STUDENT INFORMATION:

Date of Enrollment: _____ Date of Birth: _____

Full Name: _____ Sex: M F

Child's Physical Address: _____

Primary Hours of Care: From: _____ To: _____

Days of the Week in Care: M T W TH F

Meals typically served while in care: Br AM Snack Lunch PM Snack

II. FAMILY INFORMATION:

Child Lives with: _____ Mother's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

Custody: Mother Father Both Other: _____

Father's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Cell Phone: _____



**STATE OF FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES CHILD CARE
APPLICATION FOR ENROLLMENT**

III. CONTACTS:

Child will be released only to the custodial parent or legal guardian listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason, the custodial parent or legal guardian cannot be reached:

| | | | |
|-------|---------|--------|-------------|
| Name: | Address | Work # | Home/Cell # |
| Name: | Address | Work # | Home/Cell # |
| Name: | Address | Work # | Home/Cell # |

IV. HELPFUL INFORMATION ABOUT YOUR CHILD:

- Section 65C-22.006(2), F.A.C, requires a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.
- Section 402.3125(5), F.S., requires that parents receive a copy of the Child Care Facility Brochure, “Know your Child Care Facility” (CF/PI 175-24), or
- Section 65C-20.11(2)(c)(1), F.A.C., requires that parent(s) receive a copy of the family day care home brochure, “Selecting a Family Day Care Home Provider”: (CF/PI 175-28).
- Section 65C-22.006(3)(c)2., F.A.C., requires that a written copy of the family day care provider’s discipline policy be available for review by the parent(s).
- I have read and received a copy of the school tuition & fees 2024-2025 and I fully understand my financial obligations. I will cooperate and encourage my child to support and cooperate with the rules and regulations of Coral Park Christian Academy. I have been informed that the Parent Handbook is available for viewing/printing at school website: www.coralparkchristianacademy.org
- I UNDERSTAND AND CONSENT that my child enrolled at CPCA will be screened with Ages & Stages Questionnaires’ (ASQ-3), Ages & Stages Questionnaires (ASQ-2) and that I will receive the results of that screening in a letter form.
- I UNDERSTAND and consent that my child enrolled at CPCA will be screened with Florida Assessment and Student Thinking (FAST) (VPK Only) and will receive the results of that screening in a letter form.

I certify that I have read, understand, and accept all the terms and conditions described in this Enrollment Agreement and the Parent Handbook.

| | |
|------------------------------|------|
| Signature of Parent/Guardian | Date |
| Signature of Parent/Guardian | Date |

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL



2. ADDITIONAL INFORMATION FOR ENROLLMENT:

Child's Social Security # (Last 4 Digits): _____

Father's Driver License: _____

Father's Email Address: _____

Mother's Driver License: _____

Mother's Email Address: _____

3. 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.

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL



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 <i>(Please attach a copy of your child's immunization records)</i> | | | |
| Additional Medical Policies: _____ | | Signature: _____ | |
| 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. 2. I agree to provide information to the school about my child's conditions, illnesses, allergies or other needs. 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. 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. 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. 6. No medication shall be given by CPCA personnel. Contact our office in case of emergency. | | | |
| 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: _____ | | | |

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL



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

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

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 **N/A Infant**
13. Does your child need assistance at mealtime? No Yes **N/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 infections | <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? Yes 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: _____

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL



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 as long as 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.

Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian:

Date

ENROLLMENT PACKET 2024-2025 PRE-SCHOOL EMERGENCY CONTACT FORM



CHRISTIAN ACADEMY

8755 SW 16th ST.
Miami, FL 33165
305.559.9409

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 _____

Adding or removing information on the emergency contact form will be allowed only by parents or guardian. If changes are necessary the form will need to be completed again with no option for correction once submitted.