

HALIFAX ACADEMY PRE-KINDERGARTEN
1400 THREE BRIDGES ROAD
ROANOKE RAPIDS, NC 27870
2021 - 2022 SCHOOL YEAR CONTRACT

Parents, guardians, trustees or appropriate party must sign this contract and return to the school office.

Name of Student: _____

REGISTRATION FEE: Applicants must submit a **Registration Fee of \$100** along with enrollment forms for Pre-Kindergarten. Once your child is enrolled in the Pre-Kindergarten this fee becomes non-refundable and is not transferable. **Preference will be given to full-time applicants.**

In consideration of the acceptance of this contract by Halifax Academy Pre-Kindergarten the undersigned agree(s) to pay the total sum of \$_____ for the 2021-2022 school year.

	Full-time	Part-time M-F (8:30-12)
• ANNUAL PAYMENT:	\$4383.00	\$2700.00
• MONTHLY PAYMENTS:	\$ 487.00	\$ 300.00

****Please make check payable to Halifax Academy Pre-K . Pre-K payments are not accepted through the Halifax Academy Website at this time.**

Please indicate your payment preference: (Please check one of the following)

- () 1. Annual payment option/total sum to be paid by **August 16, 2021**
- () 2. Nine monthly payments of \$_____ **July, 2021 through March, 2022**

I (we) understand that:

- Payments must be paid by the **last day of the month (July-March)**. If it is paid after the last day of the month, a \$20.00 per month late fee will be assessed to your account. Late annual payers will be assessed a \$240.00 late fee.
- The child of any member whose account is delinquent may be denied attendance.
- The Pre-Kindergarten reserves the right to refuse services to any student who fails to cooperate or whose parent(s) or guardian(s) fail to cooperate. All discipline problems will be handled by the Head of School.
- **Parent or Guardian , please initial here _____**

If you withdraw your child, a letter should be sent to the school office indicating the last day the child will be attending class. Any member having a child attending one day of the month will be liable for the entire month.

I understand that in signing this contract for the coming academic year, I am agreeing to accept on behalf of my child the rules and regulations of Pre-Kindergarten and to be bound by them. If parents are legally separated or divorced, the parent with custody of child should sign and write N/A in the other space.

Print Parent or Guardian financially responsible for student.

Signature of Parent or Guardian

Date

Print Parent or Guardian financially responsible for student.

Signature of Parent or Guardian

Date

Accepted By: _____

Date

Date Registration Paid: _____

HALIFAX ACADEMY PRE-KINDERGARTEN
1400 Three Bridges Road
Roanoke Rapids, NC 27870

Date of Application: _____ For the _____ academic year

Admission is based on the following criteria:

1. Attitude of parents
2. Character and behavior of child
3. Age of child
4. Enrollment in class

Student's Name: _____
First Middle Last Preferred

Date of Birth: _____ Sex: _____ Age as of Oct. 31st _____
****Must be 4 by Oct 31st**

Child's fears or unique behaviors: _____

FATHER'S INFORMATION

MOTHER'S INFORMATION

Name: _____

Name: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Employer: _____

Employer: _____

Occupation: _____

Occupation: _____

Phone: _____ Cell: _____

Phone: _____ Cell: _____

Work Phone: _____

Work Phone: _____

Email: _____

Email: _____

Child lives with: Mother and Father Mother Father

References: (Two required – one preferred to be a member or employee of Halifax Academy)

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

Are YOU a member of Halifax Academy? YES NO

**HALIFAX ACADEMY PRE-KINDERGARTEN
EMERGENCY CONTACT INFORMATION**

1. Name: _____ Telephone: _____

Address: _____

Relationship to Student: _____

2. Name: _____ Telephone: _____

Address: _____

Relationship to Student: _____

3. Name: _____ Telephone: _____

Address: _____

Relationship to Student: _____

CHILD'S DOCTOR: _____ Telephone: _____

Address: _____

CHILD'S DENTIST: _____ Telephone: _____

Address: _____

HOSPITAL PREFERENCE: _____

I agree that the operator/director may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Parent Signature: _____ Date: _____

I, as Operator/Director, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

Operator/Director's Signature: _____ Date: _____

CHILD'S MEDICAL REPORT

Child's Name: _____ DOB: _____
Name of Parent/Guardian: _____
Parent/Guardian Address: _____

MEDICAL HISTORY (May be completed by parent)

1. Allergies: _____
2. Is your child currently under a doctor's care? _____ YES _____ NO
If YES, for what reason: _____
3. Is your child on any continuous medication? _____ YES _____ NO
If YES, what medication(s)? _____
4. Any previous hospitalizations or operations? _____ YES _____ NO
If YES, when and for what? _____
5. Any history of significant diseases or recurrent illness? _____ YES _____ NO
Diabetes? _____ Convulsions? _____ Heart Trouble? _____
Other: _____
When? _____
6. Does your child have any physical disabilities? _____ YES _____ NO
If YES, please describe: _____
7. Does your child have any mental disabilities? _____ YES _____ NO
If YES, please describe: _____

PARENT/GUARDIAN SIGNATURE: _____

PHYSICIAN TO COMPLETE THIS PART:

Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for the EPSDT program.

Height: _____ % Weight: _____ %

Head: _____ Eyes: _____ Ears: _____ Nose: _____ Teeth: _____

Throat: _____ Neck: _____ Heart: _____ Chest: _____ Abd/Gu: _____

Ext.: _____ Neurological System: _____ Skin: _____

Results of Tuberculin Test, if given: Type: _____ Date: _____ Normal: _____ Abnormal: _____

Should activities be limited? _____ YES _____ NO If yes, explain _____

Any other recommendations? _____

Signature of authorized examiner/Title: _____

Office Address: _____

Date of Examination: _____ Phone #: _____

*** A COPY OF CHILD'S UPDATED IMMUNIZATION RECORDS IS REQUIRED ***