



Inspiring Minds. Shaping Hearts.

The mission of Red Rocks Christian Preschool is to inspire the minds of children by challenging them academically and shaping their hearts to love God.

\* You must provide your child's birth certificate, immunization record and the Health Record Form attached to this application for your child's application to be considered complete.

**Enrollee Information**

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Primary Contact**

Parent / Guardian #1 \_\_\_\_\_ Cell Phone \_\_\_\_\_

Relationship to Enrollee  Father  Mother  Other \_\_\_\_\_

Email \_\_\_\_\_ Work Phone \_\_\_\_\_

Same address as student?  Yes  No

Your Address if Different from Student \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status  Married  Divorced  Single  Other \_\_\_\_\_

Parent / Guardian #2 \_\_\_\_\_ Cell Phone \_\_\_\_\_

Relationship to Enrollee  Father  Mother  Other \_\_\_\_\_

Email \_\_\_\_\_ Work Phone \_\_\_\_\_

Same address as student?  Yes  No \_\_\_\_\_

Your Address if Different from Student \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status  Married  Divorced  Single  Other \_\_\_\_\_

**Financial Responsibility**

Mother & Father  Mother Only  Father Only  Other \_\_\_\_\_

**Receive Correspondence**

Mother & Father  Mother Only  Father Only  Other \_\_\_\_\_

How Did You Hear About Red Rocks Christian Preschool?

Referral  Drive-by  Internet Search  Facebook  RRCP Website  Yelp

Have you had other children attend Red Rocks Christian Preschool in the past?  Yes  No

## Schedule

Desired Start Date \_\_\_\_\_

Please select the program your child will be attending:

- Three Year Old  
 Four Year Old

Are you looking for preschool year round or only during the school year?

- Year Round  School Year Only (September – May)

- Full Day (7:00 AM – 6:00 PM)  
 Half Day (8:00 AM – 12:00 PM)

(Due to the academic emphasis of our morning in the four-year-old program, we recommend the 5 day options so that your child can gain the most from his experience.)

Days of the Week:

- Monday  
 Tuesday  
 Wednesday  
 Thursday  
 Friday

Number of Days Per Week:

- 2 Days  
 3 Days  
 4 Days  
 5 Days

## Tuition and Fees Payment Plan Policy

### **Preschool Times:**

- **Full Day:** 7:00AM – 6:00PM
- **Part Day:** 4 hours per day – 8:00AM – 12:00PM (Additional charge for early morning drop off and late afternoon pick up)
- **Structured Program:** 8:30AM – 3:00PM (Due to the academic nature of the 4 year old program, we strongly recommend 5 days per week.)

**Snack Time:** 9:30AM and 3:30PM (provided, included in tuition fees)

**Lunch:** 12 noon (not provided)

**Registration Fee:** \$100 (one-time if continuously enrolled, non-refundable) Registration fee must be paid if a child's enrollment is not continuous such as a withdrawal and re-enrollment or if a child does not attend during the summer months.

**Materials Fee:** Included in tuition fees

**Late pick-up fees:** \$1.00 for each minute after 6:00 pm.

### **Afternoon Rates:**

- \$100 per month for families on a half-day schedule who would like to add an additional afternoon to their regular schedule.
- \$25 per afternoon for irregular schedules (billed separately)
- \$50 per day for irregular schedules (billed separately)

### **Tuition (Rates effective 9/1/2018)**

<b>Monthly Rates</b>	<b>Full Day</b>	<b>Part Day</b>
5 days per week	\$895	\$620
4 days per week	\$790	\$500
3 days per week	\$715	\$395
2 days per week	\$565	\$275

*Note: To maintain a student's enrollment in the preschool, the monthly rate must be paid even if the family is on vacation.*

**Custody / Child Lives With**

Mother & Father     Mother Only     Father Only     Other \_\_\_\_\_

**Emergency Contacts and Authorized Pickup**

Mother & Father     Mother Only     Father Only     Other \_\_\_\_\_

The following additional individuals are emergency contacts or individuals authorized to pick up my child from preschool:

Contact #1  
Name \_\_\_\_\_  
Emergency Contact  Yes  No    Relationship \_\_\_\_\_  
Authorized Pickup  Yes  No    Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

Contact #2  
Name \_\_\_\_\_  
Emergency Contact  Yes  No    Relationship \_\_\_\_\_  
Authorized Pickup  Yes  No    Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

Contact #3  
Name \_\_\_\_\_  
Emergency Contact  Yes  No    Relationship \_\_\_\_\_  
Authorized Pickup  Yes  No    Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

**Medical Information**

Doctor Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Hospital \_\_\_\_\_

Dentist Name \_\_\_\_\_  
Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Policy # \_\_\_\_\_  
Group # \_\_\_\_\_

Yes  No Does your child have any allergies? \_\_\_\_\_

Yes  No Does your child have any dietary needs? \_\_\_\_\_

Yes  No Does your child have any other special attentions/behaviors (i.e., seizures, ADD, ADHD, asthma)? \_\_\_\_\_

Yes  No Does your child have any birthmarks or blemishes?  
\_\_\_\_\_

Yes  No Is your child on a behavior management program?  
\_\_\_\_\_

**Medical Treatment Authorization**

I hereby authorize Red Rocks Christian Preschool to take my child to the aforementioned named physician or facility for medical treatment in the event of an emergency in which neither parent or guardian can be reached and do authorize the employees and agents to act for me (and/or my child) according to their best judgment and ability in case of an emergency. I hereby authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above named physician cannot respond.

I grant permission for the program supervisor or staff members to take wherever steps may be necessary to obtain emergency care if warranted. These steps may include but are not limited to the following:

- Taking the child to an emergency clinic in the company of a staff member or having the appropriate rescue personnel respond to the incident.
- Attempting to contact mother, father, or guardian.
- Attempting to contact parents/guardian through any of the persons listed as an emergency contact.
- Attempting to contact the child's physician.
- Any expenses incurred above will be the responsibility of the child's family. When appropriate, a conscientious effort will be made to contact a parent before any action is taken.
- The program will not be responsible for anything that occurs as a result of false information given at the time of enrollment.

The aforementioned emergency information details any medications, including over the counter medicines which are being given to the child. I hereby agree to the above authorization.

\_\_\_\_\_ Signature

**General Agreements**

The program assumes responsibility for the child during scheduled hours as set by the parent handbook. Any student who arrives prior to the program hours or is not immediately picked up at the scheduled time becomes the responsibility of the parents or the guardian.

I agree to hold harmless Red Rocks Christian Preschool, Red Rocks Baptist Church, and its employees from any claim or judgment that may arise by virtue of my child's activities or presence in the program.

\_\_\_\_\_ Agree (Please Initial)

**I hereby grant permission for my picture and/or my child's picture to be used in promotional materials and websites related to Red Rocks Christian Preschool and Red Rocks Baptist Church. They may photograph or videotape my child for publicity and staff training purposes.**

\_\_\_\_\_ Agree (Please Initial)

**Agreements**

My signature below affirms that all of the information contained in this application is correct, complete, and honestly presented. I understand that withholding or misrepresenting information in this application may jeopardize my child's admission.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



**MUST BE COMPLETED BY A DOCTOR**  
**CHILD MAY NOT ATTEND UNTIL THIS RECORD IS COMPLETE**

Child's Name \_\_\_\_\_ Gender \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_

**Past Illnesses**

Please check the following illnesses that the above named child has experienced and give the approximate dates.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Chicken Pox _____     | <input type="checkbox"/> Asthma _____        | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Mumps _____         | <input type="checkbox"/> Epilepsy _____  |
| <input type="checkbox"/> Diabetes _____        | <input type="checkbox"/> Poliomyelitis _____ | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Whooping Cough _____  | <input type="checkbox"/> Rubella _____       |  |
| <input type="checkbox"/> Rubella _____         |  |  |

This child  is /  is not physically and emotionally able to participate in the preschool named.

**Comments**

Surgeries, Accidents, Illnesses, Chronic Conditions, or Handicapping Problems \_\_\_\_\_  
\_\_\_\_\_

Describe any physical condition requiring special attention by staff \_\_\_\_\_  
\_\_\_\_\_

Medication prescribed \_\_\_\_\_

Allergies we should be aware of \_\_\_\_\_

Prescribed routine \_\_\_\_\_

If tuberculin test given      Date \_\_\_\_\_      Result \_\_\_\_\_

If chest X-ray taken      Date \_\_\_\_\_      Result \_\_\_\_\_

Vision \_\_\_\_\_      Hearing \_\_\_\_\_

Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization and attach to this form.

Date of the doctor's most recent examination of the child. \_\_\_\_\_

Signature of licensed physician or licensed nurse practitioner \_\_\_\_\_      Date \_\_\_\_\_

Please print name and address \_\_\_\_\_  
\_\_\_\_\_