Christian Liberty Academy
"Building Academic Accountability and Christian Character"
16-675 Milo St. Keaau, HI 96749   808-966-8866

APPLICATION PACKET

Pre-3 and Pre-4

Applicants must be three or four years old, respectively, by July 31st

PLEASE COMPLETE THE FOLLOWING:

Applicant's Name____ Gender___________

Grade Applying For__________ Date of Birth_______________ Academic Year Applying For_______

FOR OFFICE USE ONLY:

Required Forms:
______ Application Fee ($25.00 – check or money order only)
______ Copy of Birth Certificate
______ Documented "head to toe" Physical Exam & TB clearance which includes Department of Education's Student Health Record
______ D.H.S. Early Childhood Pre-K Health Record Supplement
______ Signed Financial Agreement
______ Signed Statement of Faith
______ Signed Handbook Acknowledgement

Christian Liberty Academy admits students of any race, color, religion, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, religion, national and ethnic origin, gender, or disability in administration of its educational policies, admissions policies, scholarship and loan programs, and athletic and other school-administered programs.

Revised: 4/16

APPLICATION FOR ADMISSION TO PRESCHOOL

GENERAL INFORMATION:

Today's date__________________________Grade to Enter_____________Year 20______- 20_______

Child's Legal Name____
Last First Middle

Gender_____Age_______Birth Date________________________Home Phone ___________________
Month Day Year

Mailing Address____
Street City State Zip

Primary Email Address____

Secondary Email Address____

Father's Name____Occupation_________________________

Work Phone ( )________________Cell Phone ( )_______________Marital Status_____________

Mother's Name_____________________________________Occupation__________________________

Work Phone ( )______________Cell Phone ( )______________Marital Status_____________

Student lives with ____

Legal Guardian if other than parents: ***(Please submit appropriate custody documentation)***

____ ___________________________________
Name Relationship

SCHOOL HISTORY:

School(s) previously attended:
_____________________________________Year_______Grade_______
_____________________________________Year_______Grade_______

Reason for leaving former school:____

How did you hear about Christian Liberty Academy?____

Check any of the following that may apply to your child:

_____ADD (Attention Deficit Disorder)__________LD (Learning Disability)________SE (Special Ed.)

SIBLING INFORMATION:

Name	Age	Gender	Grade	School
______________________	__________	__________	__________	_____________
______________________	__________	__________	__________	_____________
______________________	__________	__________	__________	_____________

Church you attend_________________________________Pastor__________________________

STATEMENT OF FAITH

We ascribe to the following Protestant creed in belief and practice:

I believe in the inspiration of the Bible, both the Old and New Testaments; the creation of man by the direct act of God; the incarnation and virgin birth of our Lord and Savior Jesus Christ; His identification as the Son of God; His vicarious atonement for the sins of mankind by the shedding of His blood on the cross; the resurrection of His body from the tomb; His power to save men from sin; the new birth through the regeneration by the Holy Spirit; and the gift of eternal life by the Grace of God.

I/We understand that this is what the school believes, and I/we are willing to have these beliefs taught to my / our child / children.

____

Parent Signature

____

Parent Signature

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FINANCIAL POLICIES

1. An application fee of $25.00 is due with new applications. This fee is non-refundable. Currently enrolled students may communicate their intent to re-enroll by returning a Letter of Intent along with a 100.00 registration fee (per child) in March. To be considered for re- enrollment a family MUST return this Letter of Intent and registration fee.

2. A non-refundable Comprehensive Fee is due each year in order to secure your child's spot. For currently enrolled students the due date is May 1st. For new students this non- refundable fee is due upon receipt of acceptance letter.

3. All families are required to pay a one month's tuition deposit in July of each year. This fee is held as a deposit until the month of May, or the student's last month of school. Monthly tuition payments are made in ten (10) equal payments, July through April.

4. Tuition payments must be received by the first of each month. A $15.00 late fee will be charged for each payment received after the 5th working day of each month. Failure to make payment by the 15th day of the month constitutes withdrawal of student from school.

5. A written one-month advance notice is required for withdrawal from school for any reason. Failure to give such notice will result in forfeiture of any prepaid tuition. Notice of early withdrawal from school must be given in writing by March 1st. Families failing to give notice prior to March 1st will be held responsible for tuition through the remainder of the term.

6. Refund policy:
   a. The application fee is non-refundable.
   b. The Comprehensive Fee is non-refundable.
   c. Any unused tuition fees are refundable up to March 1st of term contingent upon a 30-day written notice. No tuition fees will be refunded after March 1st.
   d. No tuition will be refunded for days or weeks missed due to illness or vacation.

FINANCIAL AGREEMENT

In signing this agreement, I acknowledge that I have read the above Financial Policies and agree to abide by it. I agree to pay the appropriate fees according to the schedule outlined. I agree to the monthly payment of tuition, which is due on or before the first of each month, July through April. If this Agreement is placed in the hands of a collection agent or attorney for collection, or if suit is brought for the collection here of , the undersigned agrees to pay, in either case, the cost of collection hereof , including a reasonable attorney fee.

____________________________ __________ ________________________

Parent's Signature Date Student's Name

BACKGROUND, HEALTH, AND OTHER INFORMATION:

Child Background

Favorite activities____

____

Primary language used at home____

Health Information

Allergies____

Health problems____

Does the child take any medication on a regular basis?______________________________

Please explain____

Please attach a signed DOE Student's Health Record from your family physician including all immunization records. Also, please attach a DHS Early Childhood Pre-K Health Record Supplement (Form 908) and Special Care Plan for a Child with Allergy (if necessary). All of these forms are included in the preschool application packet. Your child cannot be admitted without this information.

General Information

Please tell us about your child's experiences, likes, dislikes, and family routine at home. It will help us to make the preschool experience a happyone if we have this information.

____

____

____

Please tell us why you are enrolling your child

____

____

EARLY CHILDHOOD DEVELOPMENT:

Child Development Baseline

Children develop in different ways and at their own rate of progress in many dimensions. We realize that each child is an individual and we strive to give each child a preschool experience that is most beneficial to his or her individual developmental potential.

Our staff will be updating parents on the progress of their child in various developmental areas such as language development, motor skills, social development, artistic, musical, and creative development. It is helpful if we have a baseline to start our assessment. The purpose of the following questions is to establish a baseline for each individual child.

Language Development

Do you read aloud to your child?________daily______weekly_occasionally____________not yet

Does your child have his/her own books?____yes_____no

Does your child watch TV?_________daily______weekly______occasionally_______not yet Programs

watched____

Do you have a computer in the home?________yes______no

Does your child play games on the computer?_________yes______no

Number Concepts

Can your child count?________yes________not yet Recognize written numbers?_______yes______not yet

Does your child tell time?________yes_______not yet

Does your child place objects in groups?_________yes______not yet

Letter Concepts

Does your child write his/her name?________yes______not yet Can

your child name letters or sounds?____________yes______not yet

Does your child recognize stop signs and other public signs?__________yes______not yet

Artistic and Musical Development

Has your child played with playdough or clay?_________yes_____not yet

Finger paints?______yes_____not yet

Crayons, markers, chalk, or pencils?________yes_____not yet

Does your child like to sing?________yes_____not yet Dance?_____yes_____not yet

Is there children's music in your home?________yes_____no

Motor Skills

Please check activities that your child engages in:

_____Riding a tricycle

_____Playing on a swing

_____Running, jumping, and hopping

_____Climbing up a slide and sliding down

_____Ball games with other children

_____Putting puzzles together

Social Development

Does your child:

_____Play with other children of the same age (play group)

_____Play with older siblings

_____Attend day care _____Attend Sunday school

Emotional Development

Does your child cry easily?________yes_____no_____sometimes

Does your child have temper tantrums?________yes_____no_____sometimes

Would you describe your child's personality as:

_____easy going _____shy _____friendly _____outgoing

What form of discipline is used in your home?

____

____

Department of Education

Student's Health Record

Student Address Label

Name ______________________ (Last) (First) (Middle Initial)

Female ❑ Male ❑

Preschool: Entry Date __/__/__
Elementary: Entry Date __/__/__
Intermediate/Middle: Entry Date __/__/__
High: Entry Date __/__/__

Birthdate [ ][ ] Month [ ][ ] Day [ ][ ][ ][ ] Year

Parent's Name ______________ (Mother/Legal Guardian) ______________ (Father/Legal Guardian)

Allergies: ______________________

Please complete the following sections **(CHECK IF YES)**

Medical Status

Allergy (type) ❑	Cancer/Leukemia ❑	Hearing Problems ❑	Hypertension ❑	Seizures ❑	Vision Problem ❑
Asthma ❑	Chronic Cough/Wheezing ❑	Heart Disease ❑	JRA Arthritis ❑	Sickle Cell Anemia ❑	
Behavioral Problems ❑	Diabetes ❑	Hemophilia ❑	Rheumatic Heart ❑	Skin Problems ❑	

Physician's Examination Code: N-Normal; A-Abnormal; C-Corrected; R-Receiving Care

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
						R.	L.	R.	L.																		
/ /																							/ /				
/ /																							/ /				

Tuberculosis Examination
Mantoux Test (Intradermal)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic
/ /	/ /		
/ /	/ /		

Chest X-Ray

Date	Results	Location

Dental Examination

Dental Check-Up	/ /

Immunizations (Vaccines, Dates Given: Month/Day/Year)

DTaP, DTP, DT, Tdap or Td	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Polio (IPV or OPV)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hib *(Haemophilus influenzae* type b)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal Conjugate	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
MMR	Date	/ /	/ /	/ /	**Varicella**	/ /	/ /
Hepatitis A	Date	/ /	/ /				
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

Physician, APRN, PA or Clinic ______________________

***OFFICE USE ONLY** (Rev. 2010)

Health History Comments: Include Referrals and Reports. Recommendation for significant findings.
(Please Print)

Date		Signature & Title	Date		Signature & Title

Early Childhood Pre-K Health Record Supplement*

Name of Child: **Name of Child Care Facility:**

Child's DOB: **To Be Completed By The Physician**

1. Type Screening	2. Date Completed	3. Results	4. Recommendations/Follow up
Head Circumference (up to 2yrs old)		❑ Normal ❑ Abnormal	
Hgb/Hct		❑ Normal ❑ Abnormal	
Lead		❑ Normal ❑ Abnormal	
BMI (≥ 2 years old)		❑ Normal ❑ Counsel	
Developmental Screening Tool: ☐ PEDS ☐ ASQ ☐ Other ________________________		❑ No Concern ❑ Concern	

5. Medical Conditions	6. Special Care Plan Needed	7. Recommendations	8. EC Provider Use Only
Allergies/Sensitivities ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Medications/Treatments ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Special Diet prescribed by physician ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Behavioral Issues/Social Emotional Concerns ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Medical Conditions/Related Surgeries ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed

9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax

11. ***I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider***

____

Early Childhood Provider Name

12. Parent/Guardian Name

10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**

13. Parent/Guardian Signature **Date**

*Supplement to the STATE OF HAWAIʻI, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

Instructions for Completing the Early Childhood Pre-K Health Record Supplement

To Be Completed by the Physician (Please print)

1. Type of Screening: Check all that apply.

- **Head Circumference, Hgb/Hct, Lead, BMI**
- **Developmental Screening:** The screening tools listed are:
  - **PEDS**: Parent's Evaluation of Developmental Status
  - **ASQ**: Ages and Stages Questionnaire
  - **Other:** Print the name of screening tool used.

2. Date Completed

Write the date **mm/dd/year** the screening was performed. i.e., 06/01/2006.

3. Results

Mark (X) to indicate "**Normal**" or "**Abnormal**", **"No Concern"** or **"Concern"**, **"Normal"** or **"Counsel"**. If the box is marked abnormal, concern or counsel, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up

Please complete if abnormal, concern or counsel is selected.

5. Medical Conditions

Mark (X) **"None**" box for each item if the child has no **Allergies/Sensitivities**, **Medications/Treatments**, **Special Diet prescribed by physician**, **Behavioral Issues/Social Emotional Concerns**, **Medical Conditions/ Related Surgeries**. **List** type of medical condition, e.g., **Medical Condition/Related Surgeries List**: Asthma

6. Special Care Plan Needed

If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) **Yes**, next to the appropriate category. If child does not need a special care plan, mark (X) **No**.

7. Recommendations

Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."

8. Early Childhood Provider Use Only

This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.

9. Physician/NP/APRN/PA or Clinic Name

Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.

10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:

Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.

11. ***"I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood*** *provider."*

The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.

12. Parent/Guardian Name

Print the name of the Parent or Guardian

13. Parent/Guardian Signature

The Parent or Guardian must sign his/her name and write the date signed.

To be used as part of a cover letter to the preschool, parent or physician.

The purpose of the Hawaii Department of Human Services (DHS) Early Childhood Pre-K Health Record Supplement (EC-Pre-K HRS) is to provide developmentally appropriate information on the child's health, growth and developmental status for (Pre) school entry. The EC-Pre-K HRS is to be used in conjunction with the Hawaii Department of Education (DOE), Student's Health Record Form 14 2010.

The DHS EC Pre-K Health Record can be downloaded from the Hawaii Department of Human Services website, http://humanservices.hawaii.gov/ and search for Form 908. The DOE Student Health Record Form 14 can be downloaded at Department of Education website: http://www.hawaiipublicschools.org/Pages/home.aspx, click on Parents and Students, click on Enrolling in School, click on How to Enroll, look for Related Downloads and click on Student Health Record.

The child's physician is requested to complete the DOE Student Health Record Form 14 and DHS EC Pre-K Health Record Supplement. The following are directions for completing the DHS EC Pre-K Health Record Supplement.

SPECIAL CARE PLAN FOR A CHILD WITH ALLERGY

CHILD'S NAME:______________________ Date of Birth: __________

FACILITY NAME: ____

Parent(s) or Guardian(s) Name: ______________________________________

Emergency Phone Numbers: Mother _____________ Father _____________

Primary Health Provider Name: ______________ Emergency Phone: __________

Specialist's Name (if any): _________________ Emergency Phone: __________

Description of Allergy: ____
____

Describe what signs/or symptom look like:________________________________
____

Describe known triggers: ____
____

Describe treatment:____
____

Possible side effects: i.e.: no peanut products allowed______________________
____

Program modification: ____
____

When to call parent/health provider regarding symptoms or failure to respond to treatment:
____

When to consider what condition requires urgent care or reassessment: ___________
____

Physician's Name: __________________________

Physician's Signature: ______________________ Date: ______________