



All Students:

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Tuition Agreement                         |
| <input type="checkbox"/> | ACH Authorization                         |
| <input type="checkbox"/> | Emergency Contact Form                    |
| <input type="checkbox"/> | School Worx Form                          |
| <input type="checkbox"/> | Medical Report                            |
| <input type="checkbox"/> | Student Release Form                      |
| <input type="checkbox"/> | Extended Care Application (If Applicable) |
| <input type="checkbox"/> | Nutrition Opt Out Form                    |
| <input type="checkbox"/> | Religious Exemption                       |
| <input type="checkbox"/> | Transcript Requests                       |

Kindergarten Specific, in addition to the forms listed above:

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Original Birth Certificate                            |
| <input type="checkbox"/> | Kindergarten Health Assessment Completed by Physician |

## RCCA Uniforms

[www.landsend.com](http://www.landsend.com)

School Number: 900183682

**SCHOOL**  
**OUTFITTERS**  
BY LANDS' END

## Used Uniform Closet

RCCA Maintains a used Uniform Closet.

Each Item is \$5





***Tuition Agreement  
2022-2023***

Mother (    )    or    Guardian (    )		
Name: _____		
Date of Birth: _____ Social Security # _____ - _____ - _____		
Address: _____ - _____		
(Street)	(City/State)	(Zip)
Home Phone #: _____ Cell Phone #: _____		
Employer: _____ Work Phone #: _____		

Father (    )    or    Guardian (    )		
Name: _____		
Date of Birth: _____ Social Security # _____ - _____ - _____		
Address: _____ - _____		
(Street)	(City/State)	(Zip)
Home Phone #: _____ Cell Phone #: _____		
Employer: _____ Work Phone #: _____		

I understand that by signing this form I am required to ensure payment in full of all charges on my student's account by the end of the **2022-2023** school year that my child is enrolled at Renaissance Classical Christian Academy.

Student Name: \_\_\_\_\_

Registration Fee: \$ \_\_\_\_\_ Resource/Lab Fee: \$ \_\_\_\_\_ Tuition: \$ \_\_\_\_\_

\_\_\_\_\_  
Mother/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Father/Guardian Signature

\_\_\_\_\_  
Date



# Renaissance Classical Christian Academy

6427 Cliffdale Road  
Fayetteville, NC 28314  
(910) 221-0400

## AUTOMATED DRAFT AUTHORIZATION

**PLEASE COMPLETE THE FOLLOWING AUTHORIZATION AND RETURN WITH A VOIDED CHECK**

I, hereby, authorize Renaissance Classical Christian Academy (RCCA) to draft my bank account, as recorded below, for school fees of the following student(s):

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Bank Name: \_\_\_\_\_

Name on the Account: \_\_\_\_\_

Routing Number (ABA#): \_\_\_\_\_

Account Number: \_\_\_\_\_

Type of Account: (check one) ☐ Checking ☐ Savings

**YOUR ACCOUNT WILL BE DRAFTED ON THE 5<sup>TH</sup> OF EVERY MONTH, AUGUST 2021 THROUGH MAY 2022**

**School Fees to be applied:** (please check what applies)

**Date**

**Initials**

- |   |       |       |
|---|-------|-------|
| <input type="checkbox"/> First Student Monthly Tuition \$ _____                 | _____ | _____ |
| <input type="checkbox"/> Second Student Monthly Tuition (15% Discount) \$ _____ | _____ | _____ |
| <input type="checkbox"/> Third Student Monthly Tuition (15% Discount) \$ _____  | _____ | _____ |
| <input type="checkbox"/> Fourth Student Monthly Tuition (15% Discount) \$ _____ | _____ | _____ |
| <input type="checkbox"/> School Care 1 Child: \$ 225.00                         | _____ | _____ |
| <input type="checkbox"/> School Care 2 Children: \$ 420.00                      | _____ | _____ |
| <input type="checkbox"/> School Care 3 Children: \$ 615.00                      | _____ | _____ |
| <input type="checkbox"/> School Care 4 Children: \$ 810.00                      | _____ | _____ |
| <input type="checkbox"/> Other Authorized and Agreed Fee:                       | _____ | _____ |

Specify: \_\_\_\_\_

I understand that this authorization will remain in effect until May of 2023.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## EMERGENCY CONTACT AND MEDICAL INFORMATION

Child's Name

Date of Birth

M F  
Sex

Parent/Guardian's Name

Parent/Guardian's Name

( )  
Home/Cell Phone

( )  
Work Phone

( )  
Home/Cell Phone

( )  
Work Phone

Address

Address

City, State, Zip Code

City, State, Zip Code

## ALTERNATE EMERGENCY CONTACTS

Primary Emergency Contact

Secondary Emergency Contact

( )  
Home/Cell Phone

( )  
Work Phone

( )  
Home/Cell Phone

( )  
Work Phone

Address

Address

City, State, Zip Code

City, State, Zip Code

## MEDICAL INFORMATION

Physician

Preferred Hospital

Preferred Dentist

( )  
Phone Number

( )  
Phone Number

( )  
Phone Number

Insurance Company

Policy Number

Allergies/Special Health Conditions

## EMERGENCY TREATMENT AND EXTRACURRICULAR ACTIVITY AUTHORIZATION

I hereby give permission to Renaissance Classical Christian Academy licensed by the Division of Child Development to secure *INITIAL* emergency medical, dental, and/or emergency surgical treatment and to provide emergency transportation for my child. I authorize all medical and surgical treatment, laboratory, and other medical and/or hospital procedures, as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver only applies in the event that neither parent/guardian can be reached and in the case of an emergency.

I give permission for my child to participate in developmentally appropriate supervised activities outside of the fenced playground. *INITIAL* I also give permission for my child to go on field trips. I release Renaissance Classical Christian Academy and individuals from liability in case of an accident related to these activities, as long as normal safety procedures have been implemented.

I have received and reviewed a copy of the Division of Child Development and Early Education's *Summary of the North Carolina* *INITIAL* *Child Care Laws and Rules*.

Parent/Guardian's Signature

Date

Witness' Signature

Date





## RCCA School Worx Student Information Questionnaire

### Student:

_____ Last Name	_____ Middle Name	_____ First Name	_____ DOB / /	
_____ SSN	_____ Church Attends	_____ Ethnicity	_____ Gender	
_____ Street Address	_____ City	_____ State	_____ Zip Code	_____ County
_____ Scholarships			_____ Full Scholarship / Percentage	

### Parent:

_____ Relation to Student	_____ Last Name	_____ First Name	_____ Phone Number	
_____ Street Address (if different from students)	_____ City	_____ State	_____ Zip Code	_____ County
_____ E-Mail			_____ Work Number	
_____ Relation to Student	_____ Last Name	_____ First Name	_____ Phone Number	
_____ Street Address (if different from students)	_____ City	_____ State	_____ Zip Code	_____ County
_____ E-Mail			_____ Work Number	

If you would like your temporary password to our School Worx Program for you to have access to your students grades, attendance, discipline, etc. please mark yes. Thank you!

\_\_\_\_\_  
Yes

\_\_\_\_\_  
No

**Student Medical:**

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[illegible]


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[illegible]



## *Children's Medical Report*

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent/Guardian : \_\_\_\_\_

A. Medical History (may be completed by parent)

1. Is child allergic to anything? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

2. Is child currently under a doctor's care? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

3. Is child on any regular medication? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

4. Any previous hospitalizations/surgery? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

5. Any history of significant previous diseases (chronic or acute) or recurrent illness? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

6. Does the child have any physical disabilities? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

7. Does the child have any mental disabilities? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, describe - \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*

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

Height \_\_\_\_\_ Weight \_\_\_\_\_

Head \_\_\_\_\_ Teeth \_\_\_\_\_ Chest \_\_\_\_\_

Eyes \_\_\_\_\_ Throat \_\_\_\_\_ Abd/GU \_\_\_\_\_

Ears \_\_\_\_\_ Neck \_\_\_\_\_ Ext \_\_\_\_\_

Nose \_\_\_\_\_ Heart \_\_\_\_\_

Neurological System \_\_\_\_\_

Results of Tuberculin Test, if given: Type \_\_\_\_\_ Date \_\_\_\_\_

Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Should activities be limited? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Any other recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Signature of Authorized Examiner/Title*

\_\_\_\_\_  
*Date of Exam*

\_\_\_\_\_  
*Telephone Number*

***Renaissance Classical Christian Academy***  
***Student Release Authorization***  
***2022 - 2023***

Please complete this form listing any person *-including the parent/guardian(s)-* who may pick up your child at the end of each day. Your child will NOT be permitted to leave campus with anyone other than the individuals listed below, unless authorized in writing. Any person authorized by the parent/guardian must be over 18 years old and must present a picture I.D. when picking up the child.

**PLEASE COMPLETE THE FOLLOWING:**

Student's Name: \_\_\_\_\_

The following people have permission to pick up the student named above at the end of each day. We also certify that each person listed is an adult.

Name	Address & Phone	Relationship

Parent/Guardian(s)' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian(s)' Name: \_\_\_\_\_ Date: \_\_\_\_\_





**Fees & Hours:**

Morning (6:00am to 8:00am) & Afternoon (3:00pm to 6:00pm)

Please indicate the session that you want to register your child(ren) for:

\_\_\_\_\_ \$30.00 per day - Drop-In

\_\_\_\_\_ \$225.00 per month Morning and/or Afternoon for 1 Child (5 days/week)

\_\_\_\_\_ \$420.00 per month Morning and/or Afternoon for 2 Children (5 days/week)

\_\_\_\_\_ \$\_\_\_\_\_ per month Morning and/or Afternoon for \_\_\_\_ Children (5 days/week)

*\* The monthly rate for Extended Care is reduced in \$30 increments for each additional child.*

**Late Pick Up Policy:**

Our official closing time is 6:00pm. Picking up your child after 6:00 will result in a late charge of ***\$5.00 per minute that you are late***. These fees cover the costs of the caregiver that has to stay late, as their day ends at 6:00pm. Continuous late pick-ups could result in canceling the daycare agreement. If you know that you are going to be late, please try to arrange for someone else to pick up your child. Please send a note with your child or notify the school office to let them know you are going to be late, even if it is only a couple of minutes. (Late charges still apply).

**Payment Policy:**

Payment will be made by automated drafts with the tuition fee on the fifth of each month starting in August 2022 and ending in May 2023. The month of August and partial months will be prorated.

***Parents are required to submit one month written notice to cancel participation in the Extended Care program.***

**Snacks:**

Snacks are not provided. We encourage parents to send healthy snacks such as muffins, fruit, crackers, vegetables, and preferably juice or water to drink. Please do not send candy or sweet snacks.

**Child Pick Up Policy:**

Your child(ren) will not be released to anyone not listed on the student pick-up authorization form. Caregivers will not under any circumstances release your child(ren) to anyone without your consent. If someone other than the authorized pick-up person(s) listed arrives to pick up your child, we will contact you for proper permission.

***If we are unable to contact you, we will not release your child.***

**Discipline Policy:**

Discipline is the parent's responsibility. Therefore, any disrespectful, dangerous, disruptive or uncooperative behavior, on the part of students will not be tolerated. It is required that parents support the academy's discipline policy. Adherence to these policies will always remain a condition of acceptance to the school.

I have read and agree to the above procedures and policies.

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

\_\_\_\_\_  
Please print Name

\_\_\_\_\_  
Date





NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**  
Division of Child Development  
and Early Education

## Nutrition Opt Out Form

Child Care Rules .0901(d) and .1706(c) state:

When children bring their own food for meals and snacks to the program, if the food does not meet the nutritional requirements specified in Paragraph (a) of this Rule, the operator must provide the additional food necessary to meet those requirements unless the child's parent or guardian opts out of the supplemental food provided by the operator as set forth in G.S. 110-91(2) h.1. A statement acknowledging the parental decision to opt out of the supplemental food provided by the operator signed by the child's parent or guardian shall be on file at the facility. Opting out means that the operator will not provide any food or drink so long as the child's parent or guardian provides all meals, snacks, and drinks scheduled to be served at the program's designated times. If the child's parent or guardian has opted out but does not provide all food and drink for the child, the program shall provide supplemental food and drink as if the child's parent or guardian had not opted out of the supplemental food program.

I \_\_\_\_\_ plan to provide all meals, snacks and  
(Parent/Guardian Print Name)

drinks for my child and do not want his/her meals, snacks or drinks supplemented to meet the Meal Patterns for Children in Child Care Programs from the United States Department of Agriculture (USDA), which are based on the recommended nutrient intake judged by the National Research Council to be adequate for maintaining good nutrition.

Since I opted out, if I do not provide all the meals, snacks or drinks for my child, I understand that the program will provide supplemental food and drink.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**NORTH CAROLINA IMMUNIZATION LAW  
RELIGIOUS EXEMPTION  
NORTH CAROLINA GENERAL STATUTE 130A-157**

**SECTION 130A-157.** Religious exemption. - If the bona fide religious beliefs of an adult or the parent, guardian or person in loco parentis of a child are contrary to the immunization requirements contained in this Part [Chapter 130A, Article 6, Part B], the adult or the child shall be exempt from the requirements. Upon submission of a written statement of the bona fide religious beliefs and opposition to the immunization requirements, the person may attend the college, university, school or facility without presenting a certificate of immunization.

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Pursuant to the aforementioned N.C.G.S. 130A-157, I, the undersigned, declare the immunization requirements as set forth in N.C.G.S. 130A-152 contrary to my bona fide religious beliefs and request, as permitted by the law, an exemption from the immunization requirements of your institution for myself or the undersigned minor child under my legal care or guardianship.

I hereby release your institution, *Renaissance Classical Christian Academy*, its owners, staff, or representatives, from any liability based on health impairment resulting as a direct consequence of this exemption.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

☐ Check here if declaring exemption for a minor child and enter child's name below.

MINOR CHILD'S NAME \_\_\_\_\_

MINOR CHILD'S BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_





Date \_\_\_\_\_

## Request for Transcript

Dear Registrar:

The following student has enrolled in our school:

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

School for records request: \_\_\_\_\_

School Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please forward all records relating to this student:

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Birth Certificate     | <input checked="" type="checkbox"/> Transcript or Grades                    |
| <input checked="" type="checkbox"/> Immunization Records  | <input checked="" type="checkbox"/> Standardized Test Scores                |
| <input checked="" type="checkbox"/> Psychological Records | <input checked="" type="checkbox"/> Current Academic Status and Report Card |

Thank you for your kind cooperation.

Sincerely yours,

Ray Hendrickson  
Headmaster

*I hereby authorize you to release all student school records (including psychological records, if any) for the above named student who has enrolled at Renaissance Classical Christian Academy.*

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*

