



All Students:

- Tuition Agreement
- ACH Authorization
- Emergency Contact Form
- School Work Form
- Medical Report
- Student Release Form
- Extended Care Application (If Applicable)
- Nutrition Opt Out Form
- Religious Exemption
- Transcript Requests

Kindergarten Specific, in addition to the forms listed above:

- Original Birth Certificate
- Kindergarten Health Assessment Completed by Physician

RCCA Uniforms

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
2025-2026**

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 **2025-2026** 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 5TH OF EVERY MONTH, AUGUST 2020 THROUGH MAY 2021

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

	<u>Date</u>	<u>Initials</u>
<input type="checkbox"/> Student Monthly Tuition \$ _____	_____	_____
<input type="checkbox"/> Flat Rate Before/ Aftercare: \$ 300.00	_____	_____
<input type="checkbox"/> Daily fee for Before/Aftercare:\$35.00	_____	_____
<input type="checkbox"/> Other Authorized and Agreed Fee:	_____	_____

Specify: _____

I understand that this authorization will remain in effect until May of 2026.

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 Questionaire

Student:

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

Parent:

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

RCCA School Worx Student Information Questionaire

Student Medical:

Please List Any Medical Conditions

Please List Any Allergies Please Explain what happens with Allergies

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Please List any Medications (If your student has medications at school, there must be a Medication Form filled out at the Front Office. If you are unaware of form, ask Front Desk)

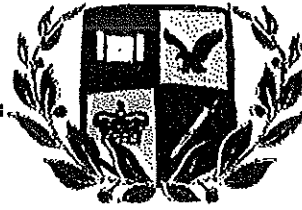
Primary Physician: _____

Location

Preferred Hospital: _____

Emergency Contact & Authorized Pick Up List

Name	Phone Number	Relation
_____ Name	_____ Phone Number	_____ Relation
_____ Name	_____ Phone Number	_____ Relation
_____ Name	_____ Phone Number	_____ Relation
_____ Name	_____ Phone Number	_____ Relation
_____ Name	_____ Phone Number	_____ Relation



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

2025-2026

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 _____

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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:

_____ \$35.00 per day - Drop-In

_____ \$300.00 per month Morning and/or Afternoon for 1 Child (5 days/week)

** The monthly rate for Extended Care is reduced in \$35 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 2025 and ending in May 2026. 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.

<p>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.</p> <p>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.</p> <p>_____ Parent/Guardian Signature</p> <p>_____ Date</p>
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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.

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

