



# Monument Academy

## New Student Registration for Preschool 2020-2021

Enrollment Packet must be completed in its entirety. Incomplete packets will not be accepted and your child's seat will not be guaranteed.

### Registration Packet Contents

- Registration Form
- Home Language Survey
- Health Information Form
- Allergies Form (Provided by Request)
- Authorization to Drop Off and Pick Up
- Preschool Tuition Contract

### Parent Provided Documentation

- Physician Authorization to Attend Preschool (Provided by Physician)
- Birth Certificate (Copy)
- Immunization Record (Copy)
- Copy of Parent Picture ID
- Custody Documentation or Power of Attorney  
(Only if student will not reside with both parents)

### Pay Fees: Tuition Deposit & Materials Fee

Entered in Infinite Campus: \_\_\_\_\_ Date: \_\_\_\_\_

# Registration Form

Student Last: \_\_\_\_\_ Student First: \_\_\_\_\_ Student Middle: \_\_\_\_\_ Start Date: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: Male Female Birth Date: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

**Ethnicity (Choose One):** Hispanic/Latino: \_\_\_\_\_ Not Hispanic: \_\_\_\_\_

**Race (Choose one or more):**

American Indian or Alaskan Native- A person having origins in any of the original people of North, Central, or South America.

Asian- A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian Subcontinent.

Black or African American- A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Pacific Islander- A person having origins in any of the peoples of Hawaii, Guam, Samoa or Pacific Islands.

White- A person having origins in any of the peoples of Europe, Middle East or North America.

**Male Head of Household:** \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Legal Guardian: Yes No

Relationship to Student: \_\_\_\_\_ Reside With: Yes No

**Female Head of Household:** \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Legal Guardian: Yes No

Relationship to Student: \_\_\_\_\_ Reside With: Yes No

**Street Address:** Address: \_\_\_\_\_

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

**Mailing Address:** Address: \_\_\_\_\_

**(If Different)** City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Names of other children in the household (Please Include Preschool Students)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

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

# Registration Form (Continued)

**Emergency Contacts: List individuals that live locally, can be reached and are authorized to pick up your student.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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Has your child ever been in a Colorado School? Yes No

Has your child ever been in the District before? Yes No

Has your child ever been assigned to any Special Programs? Yes No

**If Yes, please check which Special Programs?**

IEP                  G/T                  RTI                  504 Plan                  READ

Child Find                  Other \_\_\_\_\_

Last School Attended: \_\_\_\_\_

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

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

Country: \_\_\_\_\_

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If neither guardian nor emergency contact are available, I authorize school personnel to use their best discretion in caring for my student.

Signed By: \_\_\_\_\_ Date: \_\_\_\_\_

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School Assignment: \_\_\_\_\_ Contact /Phone: \_\_\_\_\_ Transportation: \_\_\_\_\_

Copies To:                  Parent:                  School:                  ESS(IEP):                  Accounts Payable: (Pre-K/K)

Information Entered By: \_\_\_\_\_

# Home Language Survey

Student Last: \_\_\_\_\_ Student First: \_\_\_\_\_ Student Middle: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

What Language(s) did your child use when he/she began to speak? \_\_\_\_\_

What languages are spoken to the child by the following people?

Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_ Others in the Home \_\_\_\_\_

Yes No Do the adults in your home (parents, guardians, grandparents, others) speak to each other in a language other than English all or part of the time?

If Yes, what language(s) are spoken/how often?

\_\_\_\_\_

Child's Country of Birth: \_\_\_\_\_ Date Child Entered Colorado: \_\_\_\_\_

Date Child Entered USA \_\_\_\_\_

Can information be sent home in English? Yes No

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**If a language other than English has been indicated above, your child's English proficiency may be tested.**

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Yes No Does your child understand the conversations between adults in the home when they are speaking a language other than English?

Yes No Does your child participate in the conversation even though he/she might use English?

What Language(s) did your child read? \_\_\_\_\_

What Language(s) did your child write? \_\_\_\_\_

Yes No Did your child ever attend school in another country?

If yes, in which country and during what grades? \_\_\_\_\_

What languages were used for instruction? \_\_\_\_\_

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Parent or Guardian Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

# Health Information Form

This information will help us provide the best services for your child.

Student Legal Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

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Male Head of Household: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Female Head of Household: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

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

Preferred Hospital: \_\_\_\_\_

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Dentist's Name: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

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

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Check conditions listed below if student currently has any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADD                      | <input type="checkbox"/> **Pump                | <input type="checkbox"/> Prematurity       |
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Diabetes -Type II     | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Developmental Delays  |  |
| <input type="checkbox"/> **Student has EpiPen     | <input type="checkbox"/> Head Injury           | Type of Seizures                           |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heart Condition       | _____                                      |
| <input type="checkbox"/> **Student has Inhaler    | <input type="checkbox"/> High Blood Pressure   |  |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Migraines             | Other:                                     |
| <input type="checkbox"/> Congenital Defects       | <input type="checkbox"/> Mood Disorder         | _____                                      |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Neurological Disorder |  |
| <input type="checkbox"/> Diabetes -Type I         | <input type="checkbox"/> Orthopaedic Problems  |  |
| <input type="checkbox"/> **Pen/Injections         |  |  |

## Health Information Form Continued

If you check any above, please explain:

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Is your child under medical care for any of the above health concerns:                      Yes    No

Please explain medical care provided:

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Does your student take medication regularly:                      Yes    No

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times a Day: \_\_\_\_\_

Taken for:

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Has the student had any immunization within the last year?                      Yes    No

Has the student had any serious injuries, illness or surgeries?                      Yes    No

Describe:

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Are there any physical conditions limiting the students activity?                      Yes    No

Describe:

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Does the student wear any prosthetic devices? (hearing aids, crutches, artificial limbs, braces)

Yes    No

Describe:

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Does the student wear glasses?    Yes    No

Does the student wear contact lens?    Yes    No

Does the student have a known color deficiency?    Yes    No

Optometrist Name:

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Does your student have any hearing, speech or language difficulties?                      Yes    No

Describe:

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Date of last eye exam: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_

Does the student have any special dietary limitations?      Yes      No

Describe:

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Any other health, emotional or legal concerns about the student?      Yes      No

Describe:

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Does your student have an IEP, 504 or school action plan?      Yes      No

Is the student covered by a health insurance plan or Medicaid      Yes      No

Name of Carrier:

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Previously reported condition which is now no longer a problem?

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Is there anything about your child we need to know?

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**I give permission for this information to be shared with adults in the school setting who will be working with my child on a need-to-know basis. It is the responsibility of the parent to notify the school nurse whenever there is a change in the student health status or care.**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Authorization to Drop Off and Pick Up

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

**The following persons ARE authorized to transport my child to and from Monument Academy Preschool:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**The following persons ARE NOT authorized to transport my child to and from Monument Academy Preschool:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Yes No I authorize Monument Academy preschool staff to sign my child in and out of class for the express purpose of participating in car line during the 2020/21 school year.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Print: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Daytime: \_\_\_\_\_



# Preschool Tuition Contract

Dear Parent/Guardian,

Congratulations! Your child has been accepted to the Preschool program at Monument Academy. We are delighted you and your family will be joining Monument Charter Academy for the 2020-2021 school year.

From the options below, please let us know what schedule you would like for your child:

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**Level One Options** (Must be 3 years of age prior to the first day of school)

- M/W/F AM** (7:45am – 11:00am & Fri 7:45am – 12:00pm)  
10 Payments of \$265.00
- T/TH AM** (7:45am – 11:00am)  
10 Payments of \$185.00
- T/W/TH PM** (12:00pm – 3:00pm)  
10 Payments of \$265.00
- M-TH AM** (7:45am – 11:00am & Fri 7:45am – 12:00pm)  
10 Payments of \$400.00

**Level Two Options** (Must be 4 years of age prior to first day of school)

- M-F Dual** (M-Th 7:45am - 2:45pm and Fri 7:45am – 12:00pm)  
10 payments of \$700.00
- M-F AM** (M-Th 7:45am - 11:45pm and Fri 7:45am – 12:00pm)  
10 payments of \$425.00
- T/Th All Day** (7:45am -2:45pm)  
10 payments of \$300.00
- M/W All Day** (7:45am – 2:45pm) & Fri (7:45am – 12:00pm)  
10 payments of \$420.00

The first payment plus a \$100 materials fee is due at this time. This is a **non-refundable deposit** that ensures your child's seat in the program.

The remaining payments are due the first day of each month from August to April.

Please sign the bottom of this form and return it with your non-refundable deposit. Make checks payable to Monument Academy. Call Julie Shook at 481-1950, extension 1709 if you are interested in paying by credit card, PayPal or automatic check withdrawal. Monthly tuition statements will not be mailed but will be posted on your Infinite Campus Parent Portal. Please visit [www.monumentacademy.net](http://www.monumentacademy.net) for information on how to sign up for a Parent Portal.

**Students may be dropped off at 7:45 and must be picked no later than 3:00pm. Any pickup after this time will incur a late fee of \$1.00 per minute.**

**Late Fees:** If payment has not been received by the 10<sup>th</sup> of the month a \$10 late fee will be added to the balance due. If no arrangement for payment has been made and payment is 30 days past due, administration will be notified and your child may be removed from the Preschool program. By signing this acceptance letter you agree to make payment(s) when due and to abide by the policies and regulations of Monument Academy.

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

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_