



Registration Fee
 New and Returning
 Students: \$60.00 per
 student/per year

2026-2027 Extended Care Program
 (757) 809-6606 (Lower School Campus)
 (757) 538-7151 (Upper School Campus)

STUDENT REGISTRATION

| | | | |
|--|-------------|---|-----|
| STUDENT NAME #1 | Grade Level | Nickname | Sex |
| STUDENT NAME #2 | Grade Level | Nickname | Sex |
| Address | | Home Phone: | |
| If child attends an after school program, please list the name and time/day of program (ex. sports, piano lessons, gifted class, etc): | | Date(s) of Birth: #1: _____ #2: _____ | |
| Parent(s) Email Address: #1: _____ #2: _____ | | Pertinent Medical Information: | |

PARENT/GUARDIAN INFORMATION

| | | |
|--|----------------|-------------|
| Father Name | Place Employed | Work Phone: |
| Home Address | | Cell Phone: |
| Mother Name | Place Employed | Work Phone: |
| Home Address (If different than above) | | Cell Phone: |
| Legal Guardian (If different than above) | | |

STUDENT PICKUP LIST

| | | |
|---|----|----|
| Authorized Person(s) to Pick Up Child: | 1. | 2. |
| | 3. | 4. |
| NOT Authorized Person(s) to Pick Up Child*: | 1. | 2. |
| | 3. | 4. |

** Appropriate paperwork such as custody papers shall be attached if a parent is NOT allowed to pick up child.

Suffolk Christian Academy

Extended Care Program

2026-2027

FAMILY MEDICAL CONSENT INFORMATION

To Whom It May Concern:

I, _____, parent or legal guardian of
child's name 1. _____ 2. _____ 3. _____

Do hereby give my consent to any hospital, paramedic, etc to administer the necessary treatment to my child in the event of an accident or serious illness. In addition, I give consent to the staff of Suffolk Christian Academy to transport my child by ambulance at my expense, if the situation warrants it. I also agree to inform the center within 24 hours or the next business day after my child or immediate family member of the household develops any reportable communicable diseases, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately. I will arrange to have my child picked up as soon as possible if requested by the center due to illness.

Signature of Parent/Guardian

Date of Signature

**** If there is any objection to seeking emergency medical care, a statement should be obtained from the parent/guardian that states the objection and the reason for the objection.**

EMERGENCY INFORMATION

| | | |
|--|----------------------------------|--|
| Allergies or Intolerance to Food: _____ _____ _____ | | Medicines Regularly Taken: _____ _____ |
| Child's Physician: _____ _____ | | Physician's Phone: _____ _____ |
| Insurance Company: _____ | Policy Number: _____ | |
| Two People to Contact if Parents CANNOT Be Reached (local) | Address: _____ _____ _____ | Cell Phone/Relationship to Child: _____ _____ _____ |
| | 1. _____ _____ | |
| 2. _____ _____ | Address: _____ _____ _____ | Cell Phone/Relationship to Child: _____ _____ _____ |
| | | |

A student's prescription and/or over the counter medication must be submitted to the school office in the original packaging by the parent or legal guardian. A signed medication form from the parent indicating specific instructions for the dosage and the time the medicine is to be administered. A signed note from the student's doctor is required before any prescription medication may be administered. Student must not have medication in their possession at any time.

Please refer to school handbook regarding administration of medication.

Suffolk Christian Academy

Extended Care Program

2026-2027

FINANCIAL AGREEMENT

Understanding that Suffolk Christian Academy - Extended Care Program must meet its financial obligations on time, we agree to the following policies: Yearly Registration fees are per student, non-refundable and due upon enrollment.

1. All monthly payments are due on the first of the month. A \$50.00 late charge will be assessed if my account balance is not paid in full by the 15th of that month. Any full day Extended Care attendance must be prepaid upon registration.
2. In the event of a default of payment, the account will be forwarded to the school's collection agency. The patron will be responsible for all fees incurred at that time. I understand the center reserves the right to dismiss my child from the program until payment is received.
3. To withdraw from the program, written notification must be given to the business office two weeks prior to the last day of attendance. If not, two weeks will be charged to your account.
4. Returned checks will be assessed a \$50.00 service fee.
5. There is no reduction in cost due to school closings, vacation or illness. Also, there is no reduction in cost due to inclement weather. Extended Care tuition rates were established considering all of these factors.
6. In the event of picking up a child, after closing hours, a \$1.00 late fee will be charged for each minute past closing hours until the child is picked up.
7. When full day care is offered, on days the school is closed, an additional \$50 full day fee (per student) will be billed to your account, if your student attends.

CIRCLE THE DAYS YOUR CHILD WILL ATTEND: M TU W TH F

PLEASE CHOOSE A TUITION PLAN:

| | | | |
|-------------------|-----------------|-----------------|----------------|
| 5 days a week | \$345.00/month | 1-3 days a week | \$210.00/month |
| Before Care Only | \$165.00/month | After Care Only | \$255.00/month |
| Family Cap | \$570.00/month | | |
| Single Day Rate** | \$10-25/per day | Full Day Rate** | \$50.00 |

** (not to exceed 4 visits per month)

STUDENT'S NAME(S)

1. _____ 2. _____

** Please sign below stating you have received and understand all policies set forth in the Suffolk Christian Academy Extended Care Program Handbook and above Financial Agreement.

Signature and Driver's License # Father/Guardian

Signature and Driver's License # Mother/Guardian

Date: _____

Date: _____