



TUITION-BASED PRESCHOOL STUDENT APPLICATION

STUDENT INFORMATION

First Name: _____

Middle Name: _____

Last Name: _____

Student's Date of Birth: _____

Gender: _____ Male _____ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Is the student's mailing address different than the above address?

____ Yes - (enter here) _____

____ No

HOME LANGUAGE SURVEY

Information is collected regarding the language background of each student.

What language did the child learn when he/she first began to talk? _____

What is the primary language used in the home? _____

Can the parent of the child read English? _____

FAMILY/RESIDENCY INFORMATION: THE STUDENT LIVES WITH (CHECK ALL THAT APPLY)

____ Parent/Guardian 1

____ Parent/Guardian 2

____ Parent/Guardian 1 and 2 Together

____ Parent/Guardian 1 and 2 Separately

____ Foster Family

____ Guardian(s)

____ Grandparent(s)



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PARENT/GUARDIAN 1

First Name: _____
Last Name: _____
Relationship to Student: _____
Primary Phone: _____ Secondary Phone: _____
Email: _____
Does this parent reside at the student's primary residence? _____ Yes _____ No
Employer Name: _____ Employer Phone Number: _____

PARENT/GUARDIAN 2

First Name: _____
Last Name: _____
Relationship to Student: _____
Primary Phone: _____ Secondary Phone: _____
Email: _____
Does this parent reside at the student's primary residence? _____ Yes _____ No
Employer Name: _____ Employer Phone Number: _____

HOW DID YOU HEAR ABOUT US?

_____ Web Search	_____ Press Coverage
_____ Facebook	_____ Community Event
_____ Friend	_____ School Sign
_____ Staff Member	_____ Other: _____

ADDITIONAL INFORMATION

Does a sibling currently attend Will Carleton Academy?
___ Yes, name(s) and grade(s) entering into _____
___ No

Legally, is there anyone that your child MAY NOT be released to?
___ Yes -To whom should your child not be released to: _____
___ No



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REQUIREMENTS FOR ADMISSION

Completion of this application.

Your child must be 4 years of age prior to September 1, 2021.

Bring to the Will Carleton Academy office:

- \$30 non-refundable deposit that will go towards tuition if enrolled.
- Your child's birth certificate
- Completed Child Information Record
- Up to date physical with immunization record (Your Doctor or your [Local Health Department](#) can print an Official State of Michigan Immunization Record for you.) This must be turned in prior to September 7, 2021.
- Consent for Disclosure of Immunization Information

TUITION INFORMATION

September 7, 2021 - May 27, 2022 is a total cost of \$3,825.00 or \$425 a month for 5 full days a week.

Please identify which payment option you are interested in:

_____ Payment in full (\$3,825.00)

_____ Monthly payments (\$425.00 per month)

We do participate in the Child Development and Care Program that provides a reduced tuition cost for families based on the Family Contribution Income Eligibility Scale. If you are eligible for the Child Development and Care Program, please indicate below if you are interested in more information.

_____ I am interested in more information about the Child Development and Care Program.

SIGNATURE

I certify that all information provided in this registration form is true, accurate, and complete.

Signature: _____ Date: _____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:		Date of Admission	Date of Discharge
Name of Child (Last, First, Middle Initial)			Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State Zip Code
Parent/Legal Guardian's Name	Home Phone ()	Parent/Legal Guardian's Name (Optional)	Home Phone ()
Home Address (if not child's address)	Cell Phone ()	Home Address (if not child's address)	Cell Phone ()
City	State	Zip Code	City State Zip Code
Email Address (optional)		Email Address	
Employer Name	Work Phone ()	Employer Name	Work Phone ()
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ()	
Hospital Preferred for Emergency Treatment (optional)			
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)			

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See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	()	()
2.	()	()
3.	()	()

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	()	2.	()
3.	()	4.	()

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian _____ Date Signed _____

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
LARA is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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