

**HARVEST CHRISTIAN SCHOOL  
Re-enrollment Form**

Student \_\_\_\_\_ Age/Grade \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Parent(s) \_\_\_\_\_ Daytime Phones \_\_\_\_\_

Name/Phone Numbers Of Persons To Whom Your Child May Be Released:

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**PERMISSION (please initial):**

\_\_\_\_\_ My child has permission to ride in the transportation provided for school sponsored activities.

**EMERGENCY INSTRUCTIONS:**

If I cannot be reached for emergency medical attention in the event of illness or accident, I hereby authorize Harvest Christian School to take my child to:

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|                |         |             |
|----------------|---------|-------------|
| Child's Doctor | Address | Telephone # |
|----------------|---------|-------------|

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|                    |         |             |
|--------------------|---------|-------------|
| Hospital or Clinic | Address | Telephone # |
|--------------------|---------|-------------|

**P O L I C I E S (please initial)**

- \_\_\_\_\_ 1) I have read and agree to support all school policies and statement of faith.
- \_\_\_\_\_ 2) I understand that the nonrefundable enrollment fee is due upon enrollment.
- \_\_\_\_\_ 3) I have read and agree to the tuition charge and payment schedule.
- \_\_\_\_\_ 4) I understand that all accounts are payable in advance and no credit is given for absenteeism. Late fees are \$25 after the 10<sup>th</sup> on monthly accounts and \$7 on weekly accounts after closing on Tuesday.
- \_\_\_\_\_ 5) I will submit in writing to the office any changes of address, telephones, medical, or legal information.
- \_\_\_\_\_ 6) I understand that medication will only be administered with the proper form from a physician and that all medication must be in an original container with pharmacy label.
- \_\_\_\_\_ 7) I understand that immunizations must be current and a copy furnished to the school.  
I understand that a visual and hearing screening is required yearly.  
I understand that a scoliosis screening is required for 6<sup>th</sup> and 9<sup>th</sup> graders.  
I understand that a statement of good physical health from a physician is necessary each year for a student to participate in athletics.
- \_\_\_\_\_ 8) I understand that no records will be released if accounts are delinquent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian

Date

8/02