



January 2024

Dear Parents,

This packet includes the registration information and the required enrollment forms for the 2023-2024 school year. Registration opens on January 29th.

The following must be submitted in order to register:

- **Completed** enrollment application.
- Enrollment Fee payment- Payments are made by check, cash, Zelle (chumsschool@gmail.com), or credit card through ProCare (2.5% + \$0.30 processing fee). Debit cards are **NOT** accepted.
- Required medical form and immunizations. **The medical form and a current immunization record are due in the school office or uploaded to your family account in ProCare no later than May 24, 2024.**
Returning students must present a new medical form and current immunization record each year.

Current students who submit their completed enrollment forms and fee on January 29th will receive \$25 off their enrollment fee. Forms submitted after January 29th will pay the full enrollment fee. Registration will be on a first-come, first-served basis. You will be notified only if your child does not receive placement.

The **enrollment fee** (which includes registration and supplies) may be paid in full at the time of registration or in two equal payments. The first payment must be made at registration, and the second payment must be paid by **May 15, 2024.**

- **The enrollment fee is non-refundable and non-transferable.**
- **All accounts MUST be current for the 2023/2024 school year in order to re-enroll.**

REGARDING CLASS ASSIGNMENTS: Student class assignments are made after thoughtful consideration for each child individually and as a class member. **We are unable to guarantee individual teacher requests.** Please base your registration on the class desired.

Sincerely,

Kristan Schrader
School Director



Admission Date: _____
Office use only

2024-2025 Kindergarten Enrollment

Child's Name: _____ Age as of Sept. 1, 2024 _____ yr. _____ mo.

Please select your class choice:

Kindergarten
_____ Monday – Friday 8:45 AM-2:30 PM

Early Bird 8:00 AM – 8:40 AM
_____ Tuesday/Thursday _____ Monday/Wednesday/Friday _____ Monday-Friday

Tuition and Fees for 2024-2025

Kindergarten	Monthly Tuition	Enrollment Fee
Monday – Friday 8:45 AM-2:30 PM	\$745	\$895
Early Bird		
Tuesday/Thursday	\$35	
Monday/Wednesday/Friday	\$50	
Monday - Friday	\$80	

*Tuition is paid over 9.5 months, August – May with a 1/2 month's tuition billed in August.

Payment Received \$ _____

Check Cash Zelle ProCare



**ENROLLMENT APPLICATION
2024-2025**

Please Print Clearly:

Child's Full Name _____ Prefers to be called _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Gender _____

Has your child had previous school experience other than CHUMS? _____

If so, list name of school and location _____

Please Print:

Parent/Guardian Name

Parent/Guardian Name

Home Address _____

Home Address _____

City/State/Zip _____

City/State/Zip _____

Cell Phone _____

Cell Phone _____

Email address _____

Email address _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Work Phone _____

Work Phone _____

Are parents separated or divorced? _____ If so, who has legal custody? _____

Other custodial information: _____

Does the parent or guardian have an active military ID? Yes No

Names and ages of other children in applicant's family:

Is English the primary language spoken at home? Yes No

If not, what is the primary language? _____

Does your child have medical conditions we need to be aware of? Yes No

If yes, please describe: _____

Any vision, hearing, and/or speech concerns? _____

Is your child currently receiving therapies or special services? Yes No

If yes, please explain:

Are there any medications given regularly? _____

Injuries or accidents? _____

Doctor _____

Address _____

Phone _____

Medical Authorization

I (we) authorize and consent for CHUMS personnel to seek medical treatment, administer first-aid, and secure required transportation in the event of a minor injury or emergency. Every attempt will be made to immediately contact the parent. I (we) do not hold Colonial Hills United Methodist School responsible or liable for any action necessary in the emergency care of my (our) child. I (we) will assume any expense incurred by such treatment.

Parent Name _____ Date _____

Parent Signature _____



Parent Agreement Form

Please initial each item:

___ I understand, by May 24, 2024, I must submit a **current** Medical Form signed by the doctor and me.

___ I understand, by May 24, 2024, I must submit a **current** immunization record signed by the doctor.

___ I understand that the **CHUMS Enrollment Fee is non-refundable and non-transferable.**

___ I understand that if I choose to disenroll my child, I must give CHUMS 30 days prior notice. You are responsible for paying full tuition during those 30 days.

___ I understand that the Director and staff are available for individual conferences during my child's enrollment at CHUMS, and that any problems or occurrences affecting him/her will be brought to my attention, including any serious communicable diseases found in the facility.

___ I grant my child permission to participate in all field trips (if applicable). I understand it is required for my child to be secured in a safety/booster seat. I will provide such seat and install it in the vehicle my child is riding in. I understand that if I am a parent driving on any field trips, I will provide to the school a copy of my driver's license and liability insurance.

___ I grant permission for CHUMS to photograph or videotape my child. (These may be used for class projects or in-school events.) ___ Yes ___ No

___ I grant permission for a photograph of my child to possibly be placed on our website, newsletters, brochures, CHUMS Facebook page, or other social media. Children's names are never used. Please check: ___ Yes ___ No

___ I grant CHUMS permission for my child to be cared for by CHUMS, for my child to participate in all activities of the school and use all play equipment.

I HAVE READ, UNDERSTAND, AND AGREE WITH ALL THE INFORMATION REPRESENTED IN THIS APPLICATION AND INFORMATION AGREEMENT.

Parent Name (*please print*) _____ Date _____

Student Name _____

Parent's Signature _____ Director's Signature: _____



Support Document for Students with Allergies

My child _____ has known allergies. ___Yes ___No

If yes, we ask that you complete this form for us to be completely informed and maintain safe and healthy classroom environments. **If a food allergy exists, a Food Allergy Emergency Care Plan will need to be completed and signed by your child's doctor.

Please describe allergy:

If food allergy: Does the allergy occur only when the food is ingested? _____
Does the allergy occur if the child touches or smells the food? _____

Symptoms: Please indicate symptoms to watch for

- | | | |
|--|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Throat tightness or closing |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Stomach cramps | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Red watery eyes | <input type="checkbox"/> Coughing | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Fainting or loss of consciousness |

Other: _____

Do you carry an EpiPen? _____ If yes, have you brought one for the school office? _____
(A medical authorization form must be completed.)

What specific course of action has been recommended by your Allergist/Physician?

___ Yes ___ No I need to keep medication at school for CHUMS staff to administer to my child.
A permission form must be signed for this. All medications must be in a prescription bottle. FYI: Any drugs, including over the counter medicines may not be left in the child's tote or given to his/her teacher to administer.

Parent Signature

Date



Individuals Permitted to Pick Up Children

In accordance with Child Care Regulation Minimum Standards, we must have on file the names, addresses and telephone numbers of individuals permitted to drop off and pick up your child(ren) from our school. If someone arrives to collect your child(ren) and we do not have their name on file, we **CANNOT** allow your child to leave with them.

Please list below a **minimum of two individuals (NOT INCLUDING THE CHILD'S PARENTS)**. Include the person's name, address, and telephone number. Thank you for your cooperation.

Name _____ Relationship _____

Address _____ Cell _____

Name _____ Relationship _____

Address _____ Cell _____

Name _____ Relationship _____

Address _____ Cell _____

I understand that if the name does not appear on this list, my child will not be released from school.

Parent Name (Please Print)

Child's Name (Please Print)

Parent Signature

Date

**Colonial Hills United Methodist School
2024-2025 MEDICAL FORM REQUIRED for ADMISSION**

Child's Name: _____ Birth Date: _____

Admission Requirement: Please check only one option:

1. HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above-named child within the past year and find that they are free from communicable diseases and is able to take part in school.

Health Care Professional's Signature	Date
Address	Phone

2. A signed and dated copy of a health care professional's statement is attached.

3. A medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

***If your child will be 4 or older by September 1, 2024, you will need to provide a hearing and vision screening from your physician.**

VISION	R 20/ _____	L 20/ _____		<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Signature _____	Date _____			
HEARING	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
R				
L				
Signature _____		Date _____		

Immunization Record:

I have provided the school with a copy of my child's most current immunization record.

For additional information contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to the following emergency care facility:

Emergency Medical Care Facility: _____ Phone: _____

I give consent for the Colonial Hills United Methodist School to secure all necessary emergency medical care for my child.

Signature - Parent or Legal Guardian