Admission Date: _____
Office use only

2024-2025 Little CHUMS Enrollment

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

ALL CHILDREN ENTERING OUR Little CHUMS PROGRAM MUST BE INDEPENDENTLY WALKING AND EATING.

Please select your class choice:

Little CHUMS *8:45 AM – 2:30 PM*
_____ Tuesday/Thursday
_____ Monday/Wednesday/Friday
_____ Monday - Friday

Early Bird *8:00 AM – 8:40 AM*	**Late Bird** *2:23 PM- 3:30 PM*
_____ Tuesday/Thursday	_____ Tuesday/Thursday
_____ Monday/Wednesday/Friday	_____ Monday/Wednesday/Friday
_____ Monday - Friday	_____ Monday - Friday

Tuition and Fees for 2024-2025

Little CHUMS	Monthly Tuition	Enrollment Fee
Tuesday/Thursday	$315	$465
Monday/Wednesday/Friday	$410	$560
Monday - Friday	$625	$775
Early Bird		
Tuesday/Thursday	$35	
Monday/Wednesday/Friday	$50	
Monday - Friday	$80	
Late Bird		
Tuesday/Thursday	$35	
Monday/Wednesday/Friday	$50	
Monday - Friday	$80	

Payment Received $_____ Check Cash Zelle ProCare

Dear Parents,

This packet includes the registration information and the required enrollment forms for the 2024-2025 school year.

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 into your family account in ProCare in order for your child to stsrt school.** Returning students must present a new medical form and current immunization record each year.

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

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? _____

Are there any active court orders (custody or otherwise) pertaining to your child: _____
If so, please explain: _____
_____

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.) Please check: ____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: _____

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 **(NOT INCLUDING THE CHILD'S PARENTS)** 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).**

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)

_____ Date_____

Parent 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

____ Hives	____ Vomiting	____ Throat tightness or closing
____ Itching	____ Diarrhea	____ Difficulty swallowing
____ Swelling	____ Stomach cramps	____ Difficulty breathing
____ Red watery eyes	____ Coughing	____ Dizziness
____ Runny nose	____ Wheezing	____ 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

Child's Special Care Needs

Child's Name _____ Date of Birth _____

Check all that apply:

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other:_____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment (including instructions below)
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ☐ Yes ☐ No

Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA, Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination violation of Title III, you may call the ADA Information Line (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature - Parent or Legal Guardian **Date Signed**

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/ _____		☐ Pass ☐ Fail
Signature _____	Date _____			
HEARING	1000 Hz	2000 Hz	4000 Hz	☐ Pass ☐ 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

1/09/2024 CH