



January 2023

Dear Parents,

This packet includes the registration information and the required enrollment forms for the 2023-2024 school year. Registration opens on January 30<sup>th</sup>.

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](mailto: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 no later than May 26, 2023.** 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 30<sup>th</sup> will receive \$25 off their enrollment fee.** Forms submitted after January 30<sup>th</sup> 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 10, 2023.**

- **The enrollment fee is non-refundable and non-transferable.**
- **All accounts MUST be current for the 2022/2023 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

## 2023-2024 Kindergarten Enrollment

Child's Name: \_\_\_\_\_ Age as of Sept. 1, 2023 \_\_\_\_\_ yr. \_\_\_\_\_ mo.

Please select your class choice:

| Kindergarten                                       |
|--|
| _____ M/W/F 8:45 AM-2:30 PM; T/TH 8:45 AM-12:10 PM |
| _____ M-F 8:45 AM-2:30 PM ( <i>extended days</i> ) |

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

### Tuition and Fees for 2023-2024

| Kindergarten                                   | Monthly Tuition | Enrollment Fee |
|--|-----------------|----------------|
| M/W/F 8:45 AM-2:30 PM<br>T/TH 8:45 AM-12:10 PM | \$625           | \$775          |
| Kindergarten Extended Days                     |                 |                |
| M-F 8:45 AM-2:30 PM                            | \$720           | \$870          |
| Early Bird                                     |                 |                |
| Tuesday/Thursday                               | \$30            |                |
| Monday/Wednesday/Friday                        | \$45            |                |
| Monday - Friday                                | \$75            |                |

\*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  
2023-2024**

**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:

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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:

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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 26, 2023, I must submit a **current** Medical Form signed by the doctor and me.

\_\_\_ I understand, by May 26, 2023, 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 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 participate in the following activities (if applicable):  
(Check each to give permission.)

\_\_\_ Wading Pools \_\_\_ Sprinklers

\_\_\_ 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:

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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?

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\_\_\_ 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  
2023-2024 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, 2023, you will need to provide a hearing and vision screening from your physician.**

|                 |             |             |         |   |
|-----------------|-------------|-------------|---------|---|
| <b>VISION</b>   | R 20/ _____ | L 20/ _____ |         | <input type="checkbox"/> Pass <input type="checkbox"/> Fail |
| Signature _____ | Date _____  |             |         |   |
| <b>HEARING</b>  | 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](http://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**