



# Calvary Christian Elementary School

Dr. B. Courtney McBath, Chancellor

*"For I know the plans I have for you declares the Lord, plans to prosper you and not to harm you, plans to give you a hope and a future." Jeremiah 29:11*

FOR OFFICE USE ONLY:

Family Number: \_\_\_\_\_ Date of Contract: \_\_\_\_\_ Accepted: \_\_\_\_\_

Verification:

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BC: \_\_\_\_\_

## EARLY EDUCATION CENTER APPLICATION FOR ADMISSION

### A. GENERAL INFORMATION

DATE: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

First

Middle

Last

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Sex:  Male  Female  
Month/Date/Year

### B. FAMILY INFORMATION

Parent/Guardian 1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Business: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## B. FAMILY INFORMATION (cont.)

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Parent/Guardian 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Business: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## C. CHURCH AFFILIATION

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Parent/Guardian 1: \_\_\_\_\_ Parent/Guardian 2: \_\_\_\_\_

## D. OTHER INFORMATION

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How did you learn about Calvary Christian Elementary School? \_\_\_\_\_

If there is a separation or divorce in the family or if the student resides with a legal guardian other than the parent, please complete this section.

Legal Guardian's Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Address (if different from section B): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If separated or divorced, with which parent does the child reside? \_\_\_\_\_

If divorced, please indicate the type of custody ordered by the court.  Joint  Sole  
(Attach a copy of the of the court's decision regarding custody to application)

If divorced and you would like mail-outs to go to the other parent, please fill out the following:

Parent's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## E. REFERENCES (Non-Family Members)

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1. Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## F. HEALTH AND MEDICAL INFORMATION

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Applicant's Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are there any health conditions, past or present, (e.g. asthma, diabetes, seizures, emotional disorders) which would restrict physical activity? (If not, please reply with N/A)

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Is the applicant taking any prescription medications? Please specify.  No  Yes

Has the applicant been tested for the following (please check)?

Speech/Language  Attention Deficit Disorder  Emotional Issues

Learning Disabilities  Attention Deficit Hypertension Disorder  Other (please explain)

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## G. DEVELOPMENTAL HISTORY AND BACKGROUND

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### DEVELOPMENTAL HISTORY

At what age did the child begin:

Sitting: \_\_\_\_\_ Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_ Talking: \_\_\_\_\_

Special words to describe needs: \_\_\_\_\_

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### HEALTH

Serious illness and/or hospitalizations: \_\_\_\_\_

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Special physical conditions, disabilities or allergies: \_\_\_\_\_

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Regular medications: \_\_\_\_\_

### EATING HABITS

Special characteristics or difficulties: \_\_\_\_\_

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Favorite foods: \_\_\_\_\_

Foods refused: \_\_\_\_\_

### TOILET HABITS

Is your child ever reluctant to use the bathroom? \_\_\_\_\_

Does your child have accidents? \_\_\_\_\_

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## H. APPLICATION CHECKLIST

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All of the following must be received before admission can be considered:

- Application for Admission
- Commonwealth of Virginia School Entrance Health Form
- Emergency Contact Form
- Pastoral Reference Form
- Registration Fee \$75.00
- Original Birth Certificate
- Signed Contract - Mr. Bill Walker/Accountant (757) 583-9730, ext. 41



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# FORMS

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM  
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization**

**Part I – HEALTH INFORMATION FORM**

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_  
 Student's Name: \_\_\_\_\_  
 Student's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Middle Main Language Spoken: \_\_\_\_\_  
 Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of Mother or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Name of Father or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, hospitalizations, oxygen support, hearing aid, etc.):

\_\_\_\_\_

\_\_\_\_\_

List all prescription, over-the-counter, and herbal medications your child takes regularly:

\_\_\_\_\_

\_\_\_\_\_

Check here if you want to discuss confidential information with the school nurse or other school authority.  Yes  No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance:  None  FAMIS Plus (Medicaid)  FAMIS  Private/Commercial/Employer sponsored

**I, \_\_\_\_\_ (do \_\_\_) (do not \_\_\_) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.**

**Signature** of Parent or Legal Guardian: \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature** of person completing this form: \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature** of Interpreter: \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



**Section II**  
**Conditional Enrollment and Exemptions**

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

\_\_\_\_\_  
\_\_\_\_\_

DTP/DTap/Tdap:[\_\_]; DT/Td:[\_\_]; OPV/IPV:[\_\_]; Hib:[\_\_]; Pneum:[\_\_]; Measles:[\_\_]; Rubella:[\_\_]; Mumps:[\_\_]; HBV:[\_\_]; Varicella:[\_\_]

This contraindication is permanent: [\_\_], or temporary [\_\_] and expected to preclude immunizations until: Date (Mo., Day, Yr.): |\_\_|\_|\_|\_|.

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):**|\_\_|\_|\_|\_|

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on \_\_\_\_\_.

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):**|\_\_|\_|\_|\_|

**Section III**  
**Requirements**

**For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>**

**Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).  
(requirements are subject to change.)**

**Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT**

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age/ gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided <b>TB Risk Assessment:</b> <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>EPSTDT Screens <u>Required</u> for Head Start – include specific results and date:</b> Blood Lead: _____ Hct/Hgb _____																																																		

<b>Developmental Screen</b>	<b>Assessed for:</b>	<b>Assessment Method:</b>	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
Gross Motor Skills					

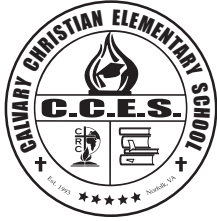
<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> <b>Unable to test – needs rescreen</b> <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)				
	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not tested			
	Distance	Both	R	L	Test used:
		20/	20/	20/	
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> <b>Unable to test – needs rescreen</b>					

<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
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<b>Recommendations to (Pre) School, Child Care, or Early Intervention Personnel</b>	<b>Summary of Findings (check one):</b> <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____ _____ _____ _____	
	___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____	
	___ <b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	___ <b>Restricted Activity</b> Specify: _____	
	___ <b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	___ <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.	
	___ <b>Special Diet</b> Specify: _____	
	___ <b>Special Needs</b> Specify: _____	
	___ <b>Other Comments:</b> _____	

<b>Health Care Professional's Certification (Write legibly or stamp):</b>	
Name : _____	Signature: _____ Date: ____/____/____
Practice/Clinic Name: _____	Address: _____
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____ Email: _____



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## EMERGENCY CONTACT FORM (confidential)

Student's Full Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Email: \_\_\_\_\_ Work Email: \_\_\_\_\_

Please list four people who are authorized to pick up your child. **All authorized persons must bring a picture ID.**

Name	Phone	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

List of current medications/allergies: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Emergency Authorization:** I, the undersigned, do hereby authorize officials at CCES to contact directly the persons named on this document. In the event that I cannot be reached in an emergency, I hereby give consent to secure appropriate treatment for my son/daughter from medical personnel or a health care facility selected by CCES medical personnel or staff. I will not hold CRC, CCES School Board or CCES staff members financially responsible for any medical fees or damages incurred in the emergency care and/or transportation of the student named above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## PASTORAL REFERENCE FORM

Please complete Part One of this application and give this form to your Pastor to complete and mail or fax directly to the following address:

**CCES Admissions**  
**2331 E. Little Creek Road**  
**Norfolk, VA 23518**  
**Fax: (757) 480-5689**

### PART ONE

Parent's Name: \_\_\_\_\_

Parent's Address: \_\_\_\_\_

This family has applied for their child to attend Calvary Christian Elementary School. Our goal is to compliment the value taught in a Christian home. We would appreciate specific information about the family so that we know their background and assess their suitability for our school.

### PART TWO – To be completed by the Pastor

How long have you known this family? \_\_\_\_\_

Church membership:  Mother  Father  Both Parents

Church attendance:  Regular  Occasional  Seldom

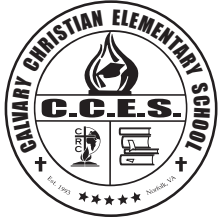
Is the family active in your church beyond Sunday attendance?  Yes  No

If yes, please explain: \_\_\_\_\_

Are there any concerns about the family that should be considered before approving the application to CCES? \_\_\_\_\_

Print Pastor's/Designee's Name: \_\_\_\_\_

Pastor's/Designee's Signature: \_\_\_\_\_



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## EARLY EDUCATION CENTER TUITION INFORMATION 2011 - 2012

### FEES

Registration Fee per Child                      \$75.00 (one-time fee: non-refundable)

### TUITION

	Age	Monthly	Weekly
Infants	6 weeks - 15 months	\$720.00	\$180.00
Toddlers	16 months - 23 months	\$620.00	\$155.00
K2	24 months - 36 months	\$560.00	\$140.00

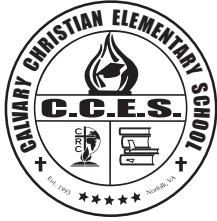
### SMART TUITION PAYMENT PLAN

SMART Tuition is a payment plan that offers parents a variety of options for paying tuition. These options include direct draft, monthly invoices and online payments. There is an annual fee of \$38.00 per child, per family.

Tuition payments must be made on either the 5<sup>th</sup> or 20<sup>th</sup> of each month using one of the SMART options. Additional information on the payment options will be discussed with you when you complete your enrollment contract.

The registration fee must be made via check, money order or credit card no longer than August 31, 2011. We do not accept cash. All subsequent payments must be made on either the 5<sup>th</sup> or 20<sup>th</sup> of each month using one of the SMART options. If your account falls 30 days in arrears, your student's name will be removed from CCES's Enrollment Roster.

Additional information on your payment options will be provided by the Accounting/Finance Department at the time your Enrollment Contract is signed. Please contact Bill Walker at (757) 583-9730, ext. 41 in order to schedule an appointment for the execution of your contract.



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## EARLY EDUCATION CENTER SUPPLY LIST

### INFANTS

- 2 boxes of tissues
- 1 box of quart size Ziploc bags
- 1 box of gallon size Ziploc bags
- 1 pack of baby wipes (labeled)
- 1 pack of Pampers (labeled)
- 2 crib sheets (labeled)
- 2 crib blankets (labeled)
- 3 bibs (labeled)
- 3 complete change of clothing (labeled)
- 1 large bottle of hand sanitizer (no rinse)
- 1 favorite toy to stay
- 2 vinyl bibs (labeled)
- 1 diaper cream
- 1 pacifier to stay in class
- 8-10 servings of baby food from home  
(labeled and dated)

### K2

- 1 box of gallon size Ziploc bags
- 1 box of sandwich size Ziploc bags
- 2 boxes of tissues
- 1 large bottle of hand sanitizer (no rinse)
- 1 pack of baby wipes (labeled)
- 1 package of pull-ups (labeled)
- 10 training pants and rubber pants sets (labeled)
- 1 fitted crib sheet (labeled, no flat or full size)

### TODDLERS

- 1 box of gallon size Ziploc bags
  - 1 box of sandwich size Ziploc bags
  - 2 boxes of tissues
  - 1 large bottle of hand sanitizer (no rinse)
  - 2 packs of baby wipes (labeled)
  - 1 package of pampers/pull-ups (labeled)
  - 2 fitted crib sheets (labeled, no flat or full size)
  - 2 crib blankets (labeled, no sleeping bags)
  - 2 complete change of clothing (labeled)
  - 2 vinyl bibs (labeled)
  - 1 painting smock for crafts (labeled)
  - 1 sippy cup (bring in daily)
- 
- 1 crib blanket (labeled, no sleeping bags)
  - 1 complete change of clothing (labeled)
  - 1 painting smock for crafts (labeled)
  - 1 construction paper (associated)
  - 1 magic markers
  - 2 stick glue
  - 2 washable 8 colors water paint
  - 1 pencil box (for supplies)
  - 1 small book bag

**NOTE:** Some items may need to be replenished later during the school year.

**Please! Please! Please! Label all items.**