Registration

$100 New Registration Fee (Non-Refundable)
$50 Re-registration Fee (Non-Refundable)

All areas must be completed. Do not skip sections. If not applicable, write “N/A.”

Section				
Student	**Student Full Name**		Age: Birth Date:	Grade Entering:
	Student’s Physical Address:	Mailing Address:	❑ Male ❑ Female	Professed faith in Jesus? ❑ Yes ❑ No
Title V	**Please check if receiving the following** ❑ (TANF) Temporary Assistance to Needy families ❑ Food Stamps ❑Foster Care	Ethnicity: Hispanic/Latino ❑ Yes ❑ No	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian or Pacific Islander ❑White ❑ Two or more races.	
Custody	**Parents/Guardians Are:** ❑ Married ❑ Separated ❑ Divorced ❑ Living Together ❑ Widow/Widower ❑ Foster Parent			
	Student resides with: ❑ Parents ❑ Mother ❑ Father ❑ Grandparents ❑ Legal Guardian ❑ ____________			
	Is student part of a Custody/Court/Restraining Order? ❑ Yes ❑ No ***If yes, please attach copy of order with this application.*** Is anyone specifically prevented from having access to this student? ❑ Yes ❑ No ***If yes, please list name(s):***			

Section				
Parent/Guardian 1	**Name**	Relationship to Student	Best Contact # Is this a cell#? ❑Yes ❑No	Work#
	Physical Address ❑Same as Student	Email		Emergency Alert ❑ Email ❑Cell
	Mailing Address	Church Attending	Religion	Professed faith in Jesus? ❑ Yes ❑ No
	Employer Name and Address	Job Title		
		Custody: ❑ Full	❑ Legal ❑ Physical Custody	❑None
Parent/Guardian 2	**Name**	Relationship to Student	Best Contact # Is this a cell#? ❑Yes ❑No	Work#
	Physical Address ❑Same as Student	Email		Emergency Alert ❑ Email ❑Cell
	Mailing Address	Church Attending	Religion	Professed faith in Jesus? ❑ Yes ❑ No
	Employer Name and Address	Job Title		
		Custody: ❑ Full	❑ Legal ❑ Physical Custody	❑None
Parent/Guardian 3	**Name**	Relationship to Student	Best Contact# Is this a cell#? ❑Yes ❑No	Work#
	Physical Address ❑Same as Student	Email		Emergency Alert ❑ Email ❑Cell
	Mailing Address	Church Attending	Religion	Professed faith in Jesus? ❑ Yes ❑ No
	Employer Name and Address	Job Title		
		Custody: ❑ Full	❑ Legal ❑ Physical Custody	❑None

Insurance			
	Family Physician	Phone	Preferred Hospital
	Family Dentist	Phone	Dental Insurance: ❑ Yes ❑ No
	Insurance Company	Member Number	Group Number
	Name of Policy Holder	DOB	
	Allergies:		
	Medical Condition:		

*****Please include child's current immunization record (or date this will be provided) OR Signed & Notarized Parent Affidavit of Religious Exemption of Vaccination OR Medical Waiver*****

Medication	**Prescribed Medication/Dosage** ***Must come in original bottle w/doctor's note***		**Home**	**School**
			❑	❑ **Yes** ❑ **No**
			❑	❑ **Yes** ❑ **No**

Education History	**Has student previously received**		**Where/When**	**Educational Assistance**		**Where/When**
	IEP (Individual Education Plan)	❑ Yes ❑ No		Speech Therapy	❑ Yes ❑ No	
	504 Plan	❑ Yes ❑ No		Occupational Therapy	❑ Yes ❑ No	
	Disability of any Kind	❑ Yes ❑ No		Behavioral Therapy	❑ Yes ❑ No	
	Tutoring	❑ Yes ❑ No		Behavioral Plan	❑ Yes ❑ No	
	Last Enrolled School*		Dates Attended		Last Grade Completed	
	School Address		Phone Number		Fax Number	
	*If homeschooled, please identify curriculum used and proof of grade level completed.					

Preschool	❑**3 Year Old Program**:	❑**4 Year Old Program:**	
	❑5 Full Days (8:00am – 3:00pm)	❑5 Full Days (8:00am – 3:00pm)	

*****Please include a photocopy of your child's birth certificate with this application*****
Please include a letter of recommendation from your child's Youth Pastor (5th grade-8th grade students). Please include a recommendation from your family Pastor for your family.

List of Emergency Contacts and/or Adults authorized to Pick-up student (Other than Parents)

Name	Relationship	Phone #	Emergency Contact?	Pick-up Person?
			❑	❑
			❑	❑

Financial Arrangements:

❑ I/We will pay tuition in full for the school year as directed by the Financial Director.

❑ I/We will pay tuition by enrolling in the automatic payment plan with FACTS within three (3) days of enrollment.

❑ Person responsible for tuition if different from parents/guardians:______________________________

Phone Number:________________________________ Address:______________________________

Parent/Guardian Signature:____**Date:**____________________

All required papers & registration fee must be turned in before student is considered enrolled.

2022-2023 Tuition & Fee Schedule
Shine Pre-School 3 & 4 Year Old Program

Registration Fee

New Students $100.00

Returning Students .... $ 50.00

Registration Fee must be submitted with the application and is non-refundable

*Multi-Student Discounts	First Child	Second Child	Third Child
Fee Total	**$5,900.00**	**$5,600.00**	**$5,300.00**
10 Months	***$590.00/month**	***$560.00/month**	***$530.00/month**

Monthly payment rates. *Multiple student discounts apply only to full-time students.

3 Year Olds

Your child must be 3 by August 31st and be able to use the restroom independently

Five Full Days (8am to 3pm).. $5,900.00

4 Year Olds

Your child must be 4 by August 31st

Five Full Days (8am to 3pm).. $5,900.00

BEFORE/AFTER CARE (7:00AM - 7:40AM & 3:00PM - 5:30PM)

Weekly ....1st child $70.00, 2nd sibling $60.00, 3rd+ sibling $55.00
Weekly a.m. only.. $25.00
Weekly p.m. only..1st child $55.00, 2nd sibling $45.00
Daily Drop-Off a.m. & p.m..1st child $18.00, 2nd sibling $15.00
Daily Drop-Off a.m. only $10.00
Daily Drop-Off p.m. only $15.00

Terms:

- Enrollment is dependent upon a successful interview.
- 5% discount on Tuition paid in full by July 31st.
- Tuition payment plans are managed by FACTS Management. There is a one-time non-refundable fee. https://online.factsmgt.com/signin/4FYNS
- Multi-Family, License Local Pastor discounts available.
- Incidental expenses: school supplies & field trips.

FINANCIAL POLICIES

1. Registration fee is due along with the enrollment packet.
2. Meet with Financial Director.
   a. Tuition may be Paid-in-Full (in house).
   b. FACTS: We partner with FACTS Management Company to manage our tuition payment program and financial assessment. You may choose either the 1st, 5th, or 20th of each month as your payment date. Automatic payments can be made from a checking or savings account or from a variety of debit/credit cards (if a debit/credit card is used, a service fee of 2.85% will be charged to your account). *****You are **not officially enrolled** until you have completed enrollment in FACTS or have paid in full.
3. After three attempts by FACTS to collect an overdue payment, the student may be suspended until the overdue bill is paid.
4. If a student's tuition is not current, the student may not re-register in LCS until all fees are paid in full.
5. In the event any check is returned to the school from the bank, the Financial Director will notify the parent and a return check fee (from the bank and the school) will be charged to your account. The LCS Board reserves the right to ask that future payments be made in cash, certified check or money order.
6. If a student is withdrawn during the school year, parents are responsible for the tuition for the entire month in which the withdrawal is made. Students on a monthly payment plan will be re-calculated on a per-diem basis. No refunds for enrollment, book fees, or other charges will be made. I also understand that given the Covid-19 pandemic (and any other unforeseeable circumstances that prevent this contract from being fulfilled from circumstances that may arise which are beyond the school's control), the current school year may involve changes in my financial responsibilities to Lighthouse Christian School that I will be required and prepared to follow. I understand that specific details will be provided in a timely fashion concerning changes.
7. SHINE charges for before/after school care can be charged to your FACTS account or paid in-house on the first day of each week.
8. Scholarship may be available for students in Kindergarten through 8th grade. An online application is available through online.factsmgt.com ($30.00 registration fee for this service applies). All information provided is kept strictly confidential.
   Discounts:
   - ***Paid-in-Full discount of 5% if payment is made on or before July 31st h.***
   - ***Multi-family discounts will be given to students Kindergarten – 8th grade.***
   - ***Pastoral discount will be given to students who have a parent that is an active licensed Pastor.***
   - ***Report cards will not be issued nor will permanent records be forwarded when there is an unpaid balance until payment is made in full.***

THIS POLICY IS AN AGREEMENT BETWEEN:
STUDENT NAME: ____

SIGNATURE OF PARENT/GUARDIAN:
____DATE:_____________

FINANCIAL DIRECTOR: ____DATE_____________

NOTICE OF COVID-19 NON-LIABILITY

Since Lighthouse Christian School (LCS) has taken reasonable steps to reduce the environmental, health, and safety risks, neither LCS nor any of its officers, directors, employees, agents or representatives is liable, personally or professionally, for any acts or omissions, negligent or otherwise, related to the transmission of COVID-19 or any other pathogen.
By sending your child to LCS, you acknowledge that you recognize and agree to the risks.

Student(s)' Name(s)

____

____

____

____

*Parent//Guardian Name: (Please Print)____

Parent/Guardian Signature:____________________________________ Date: _____________

*Parent//Guardian Name: (Please Print)____

Parent/Guardian Signature: ___________________________________ Date: ______________

28157 Lighthouse Crossing Dagsboro, DE 19939 Telephone: 302-732-3309 Fax: 302-732-6974

DELAWARE STUDENT HEALTH FORM – CHILDREN
PreK- Grade 6

To be completed by licensed healthcare provider:
Physician (MD or DO), Clinical Nurse Specialist (APN), Advanced Practice Nurse (APN), or Physician's Assistant (PA)

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) and your health care provider (Parts I, II, and III). All students in Delaware public schools must provide documentation of current immunizations. Additionally, a current (within 2 years) health examination is required upon school entry.

Talk with your health care provider about important issues[1] regarding your child, such as:

- ☐ **School** (readiness or adaptation, after school, parent-teacher communication, maturity, performance, special services)
- ☐ **Mental and Physical Activity** (healthy weight, well-balanced diet, physical activity, limited screen time)
- ☐ **Emotional Well-Being** (family time, social interactions, self-esteem, resolving conflicts, friends)
- ☐ **Physical Growth & Development** (dental care, healthy eating, puberty)
- ☐ **Injury & Illness Prevention & Safety** (seat belt or booster seat, bicycle safety, swimming, abuse protection, guns, fire safety, supervision, sunscreen, internet, infection, disaster planning)
- ☐ **Immunizations**

Immunizations *Required* for Newly Enrolled Students at Delaware Schools

KINDERGARTEN[2]:

- ☐ **DTaP/DTP:** 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required.
- ☐ **Polio**: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR**[3]: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- ☐ **Hep B**[3]: 3 doses.
- ☐ **Varicella**[4]: 2 doses. The 1st dose should be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

GRADES 1-6:

- ☐ **DTaP/DTP**: 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required. Students who start the series at age 7 or older only need a total of 3 doses. A booster dose of Td or Tdap is recommended by the Division of Public Health for all students at age 11 or five years after the last DTap, DTP, or DT dose was administered –whichever is later.
- ☐ **Polio**: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR**[3]: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- ☐ **Hep B**[3]: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- ☐ **Varicella**[4]: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

Immunizations *Strongly* Recommended by the Delaware Division of Public Health

- ☐ **Influenza (seasonal) vaccine:** *each year* for *all* children (6 months and up).
- ☐ **Tetanus-Diphtheria-Pertussis (Tdap):** booster at age 11 or five years after the last dose
- ☐ **Meningococcal (MCV4):** all children at 11 or 12 years, and a booster does at age 16
- ☐ **Human papillomavirus vaccine (HPV):** all girls and boys (ages 11 or 12)
- ☐ **Pneumococcal vaccine (PCV13):** children with specific risk factors
- ☐ **Pneumococcal vaccine (PPSV):** certain high risk groups
- ☐ **Hepatitis A:** unvaccinated children who are or will be at increased risk

[1] Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd ed.) AAP, 2008
[2] Children who enter school prior to age four shall follow current Delaware Division of Public Health recommendations.
[3] Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.
[4] Varicella disease history must be verified by a health care provider to be exempted from vaccination.

PART I – HEALTH HISTORY

To be completed by parent/guardian prior to exam
The healthcare provider should review and provide comments in the last column.

Name:_________________________ **Gender:**__________ **DOB:**____________________
Date:_________________________ **Examiner:**______________________________

	PARENT		HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	
Serious injury or illness?			
Medication?			
Hospitalizations? When? What for?			
Surgery? (List all) When? What for?			
Ear/Hearing problems?			
Heart problems/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Allergies (food, insect, other)?	Yes	No	
Family history of sudden death before age 50?	Yes	No	
Child wakes during the night coughing?	Yes	No	
Diagnosis of asthma?	Yes	No	
Blood disorders (hemophilia, sickle cell, other)?	Yes	No	
Excessive weight gain or loss?	Yes	No	
Diabetes?	Yes	No	
Loss of function of one or paired organs (eye, ear, kidney, testicle)?			
Seizures?	Yes	No	
Head injuries/Concussion/Passed out?	Yes	No	
Muscle, Bone, or Joint problem/Injury/Scoliosis?	Yes	No	
ADHD/ADD?	Yes	No	
Behavior concerns?	Yes	No	
Eye/Vision concerns? ☐Glasses ☐Contacts ☐Other________________________	Yes	No	
Dental concerns? ☐Braces ☐Bridge ☐Plate ☐Other? Date of exam ________________________	Yes	No	
Other diagnoses?	Yes	No	
Does your child have health insurance?	Yes	No	
Does your child have dental insurance	Yes	No	

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian
Signature **Date**

CHILD'S NAME____

PART II – IMMUNIZATIONS

Entire section below to be completed by MD/DO/APN/NP/PA
Printed VAR form may be attached in lieu of completion.

Immunizations – Shaded *Vaccines Required. Regulations is located at* *Title 14 Section 804 Immunizations*.

DTaP/ DT / /	DTaP/ DT / /	DTaP/ DT / /	DTaP/ DT / /	DTaP/ DT / /
OPV/ IPV / /	OPV/ IPV / /	OPV/ IPV / /	OPV/ IPV / /	OPV/ IPV / /
PCV7/ PCV13 / /	PCV7/ PCV13 / /	PCV7/ PCV13 / /	PCV7/ PCV13 / /	PCV7/ PCV13 / /
Hib / /	Hib / /	Hib / /	Hib / /	
MMR / /	MMR / /	HepB /HepB-2 / /	HepB /HepB-2 / /	HepB / /
VAR / /	VAR / /	RV-2/ RV-3 / /	RV-2/ RV-3 / /	RV-3 / /
MCV4 / /	MCV4 / /	HPV / /	HPV / /	HPV / /
Hep A / /	Hep A / /	Td/ Tdap / /	Td/ Tdap / /	Td / /
Influenza / /	Influenza / /	PPSV23 / /	PPSV23 / /	
Other: / /	Other: / /	Other: / /	Other: / /	Other: / /

Child is fully immunized per DPH/CDC recommendations (refer to cover page) ☐ Yes ☐ No

PART III – SCREENING & TESTING

Entire section below to be completed by MD/DO/APN/NP/PA

Screen	**Height:** _______ **Weight:** _______ **BMI:** _______ **BMI Percentile:** _______ **BP:** ________ **Pulse:** ________ **Other:** ________ (inches) (pounds)
Dental Screen	☐ **Problem Identified:** Referred for treatment ☐ **No Problem:** Referred for prevention ☐ **No Referral:** Already receiving dental care
Tuberculosis Screen	All new enterers must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry. **Risk Assessment:** **Date**__________ **Results**: ☐ Test Required ☐ Test Not Required **Mantoux Skin Test:** **Date**__________ **Results**:_____________________MM **Other:** (type)________________ **Date**__________ **Results**:_____________________MM
Lead Test	Blood lead test required for children age 6 months through 6 years **Date**:____________ **Results**:____
Other Screen	**Hearing: Type**:________________ **Date**:_________ **Results**:_________________ **Referral:** ☐ No ☐ Yes ______ Date **Vision: Type**:________________ **Date**:_________ **Results**:_________________ **Referral:** ☐ No ☐ Yes ______ Date **Other: Type**:________________ **Date**:_________ **Results**:_________________ **Referral:** ☐ No ☐ Yes ______ Date

CHILD'S NAME_______________________________________

PART IV – COMPREHENSIVE EXAM

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	REFERRAL	HEALTHCARE PROVIDER COMMENT
General Appearance				
Skin				
Eyes				
Ears				
Nose/Throat				
Mouth/Dental				
Cardiovascular				
Respiratory				
Thyroid				
Gastrointestinal				
Genito-Urinary				
Neurological				
Musculoskeletal				
Spinal examination				
Nutritional status				
Mental health status				

FOR CHRONIC & LIFE THREATENING CONDITIONS:

Children with life-threatening conditions need an emergency care plan for school.

Please attach care plan, protocols, and/or emergency care plan.

Recommendations or Referrals:____

____

____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	NO

Print Name: ___________________________ **Signature:** ______________________________**Date:** ______

☐**Physician (MD or DO)** ☐**Clinical Nurse Specialist (APN)** ☐**Advanced Practice Nurse (APN)** ☐**Physician Assistant (PA)**

Address: ____**Phone:** _______________________

School Policies Acknowledgement & Release Form

Student Name: ____ Grade_______

LCS SCHOOL HANDBOOK Initials______

I hereby affirm that I have seen and reviewed the Lighthouse Christian School Handbook with an Administrator. This handbook is located on the school website at www.lighthousechristianschool.com. I will discuss it with my student.

Policies:

Financial Initials______

Parent Statement Initials______

Christian Code of Conduct Initials______

Discipline Initials______

Dress Code Initials______

Technology Usage Initials______

Athletic Initials______

Food & Beverage Initials______

Medication & Illness Initials______

Attendance Initials______

Contact and Communication Initials______

Fire and Emergency Procedures Initials______

On-site Field Trips Initials______

I give permission for my student to participate in on-site school-sponsored field trips for educational purposes that may include walking anywhere on campus.

POSTING OF STUDENT WORK OR PICTURE ON WEBSITE Initials______

I hereby authorize and give full consent to Lighthouse Christian School or its authorized representative to reproduce, publish, and copyright all photographs, videos, and student work of my child to be used in Lighthouse Christian School literature, advertisements, websites, and other promotional purposes. Additionally, I agree that the use of the photographs, video footage, and student works may be used for an unlimited amount of time. I will not seek compensation for the use of any said items. All copies, masters, negatives, positives, and other related materials are the property of Lighthouse Christian School. Furthermore, I agree that the use of photographs, video footage, and student works does not constitute in any manner a waiver of Lighthouse Christian School's policies, programs, rules, nor does use constitute an agreement of acceptance or continuance of my child's enrollment.

Emergency Medical Release Initials______

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I understand that there are risks/dangers involved with participation in school activities. In consideration of my child being allowed to participate in school activities, I assume responsibility for those ordinary and reasonable risks associated with activities. **I agree to hold harmless Lighthouse Christian School, its affiliated organizations, employees, agents, and representatives, and volunteers, from any and all claims arising from my child's participation.** This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstances are proved in a court of law, I acknowledge and agree that the school can assume no financial liability beyond its actual liability insurance policy in force.

In case of accident, illness, or other emergency, I request that the school contact me. If the school cannot reach a parent/guardian after conscientious effort, I give permission for school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists, I give permission for school staff to immediately call the paramedics and then contact me as soon as possible. I authorize and consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which, in the best judgment of a licensed physician or dentist, if deemed advisable. I agree to assume the financial responsibility for expenses incurred as a result of those services being provided and/or emergency medical transportation if needed.

By signing below, I/We acknowledge and represent that I/we have READ and FULLY UNDERSTAND this Emergency Medical Release; that I/We sign it VOLUNTARILY with full intent to be bound by this release.

Parent/Guardian:

Printed Name: ____ Date: ____________________

Signature____