



# 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."**

<b>Student</b>	<b>Student Full Name</b>		Age:	Birth Date:	Grade Entering:	
	Student's Physical Address:		Mailing Address:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Title V</b>	<b>Please check if receiving the following</b> <input type="checkbox"/> (TANF) Temporary Assistance to Needy families <input type="checkbox"/> Food Stamps <input type="checkbox"/> Foster Care		Ethnicity: Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or more races.	
	<b>Parents/Guardians Are:</b> <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Living Together <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Foster Parent					
<b>Custody</b>	Student resides with: <input type="checkbox"/> Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparents <input type="checkbox"/> Legal Guardian <input type="checkbox"/> _____					
	Is student part of a Custody/Court/Restraining Order? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*If yes, please attach copy of order with this application.</i>					
	Is anyone specifically prevented from having access to this student? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*If yes, please list name(s):</i>					
<b>Parent/Guardian 1</b>	<b>Name</b>		Relationship to Student	Best Contact #	Work#	
	Physical Address <input type="checkbox"/> Same as Student		Email	Is this a cell#? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Mailing Address		Church Attending	Religion	Emergency Alert <input type="checkbox"/> Email <input type="checkbox"/> Cell	
	Employer Name and Address		Job Title			
	Custody: <input type="checkbox"/> Full <input type="checkbox"/> Legal <input type="checkbox"/> Physical Custody <input type="checkbox"/> None					
<b>Parent/Guardian 2</b>	<b>Name</b>		Relationship to Student	Best Contact #	Work#	
	Physical Address <input type="checkbox"/> Same as Student		Email	Is this a cell#? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Mailing Address		Church Attending	Religion	Emergency Alert <input type="checkbox"/> Email <input type="checkbox"/> Cell	
	Employer Name and Address		Job Title			
	Custody: <input type="checkbox"/> Full <input type="checkbox"/> Legal <input type="checkbox"/> Physical Custody <input type="checkbox"/> None					
<b>Parent/Guardian 3</b>	<b>Name</b>		Relationship to Student	Best Contact#	Work#	
	Physical Address <input type="checkbox"/> Same as Student		Email	Is this a cell#? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Mailing Address		Church Attending	Religion	Emergency Alert <input type="checkbox"/> Email <input type="checkbox"/> Cell	
	Employer Name and Address		Job Title			
	Custody: <input type="checkbox"/> Full <input type="checkbox"/> Legal <input type="checkbox"/> Physical Custody <input type="checkbox"/> None					

<b>Insurance</b>	<b>Family Physician</b>	Phone	Preferred Hospital
	Family Dentist	Phone	Dental Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> 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\*\*\***

<b>Medication</b>	<b>Prescribed Medication/Dosage</b> <i>Must come in original bottle w/doctor's note</i>			<b>Home</b>	<b>School</b>	
				<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Education History</b>	<b>Has student previously received</b>		<b>Where/When</b>	<b>Educational Assistance</b>	<b>Where/When</b>	
	IEP (Individual Education Plan)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	504 Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No		Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Disability of any Kind	<input type="checkbox"/> Yes <input type="checkbox"/> No		Behavioral Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tutoring	<input type="checkbox"/> Yes <input type="checkbox"/> No		Behavioral Plan	<input type="checkbox"/> Yes <input type="checkbox"/> 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.						
<b>Preschool</b>	<input type="checkbox"/> <b>3 Year Old Program:</b>		<input type="checkbox"/> <b>4 Year Old Program:</b>			
	<input type="checkbox"/> 5 Full Days (8:00am – 3:00pm)		<input type="checkbox"/> 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 (5<sup>th</sup> grade-8<sup>th</sup> 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?
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

**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  
Kindergarten & 1<sup>st</sup> Grade

**Registration Fee**

New Students .....	\$100.00
Returning Students .....	\$ 50.00
Admission Testing Fee (Kindergarten & 1 <sup>st</sup> grade).....	\$ 25.00

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

*Testing Fees due at time of test and are non-refundable*

*Multi-Student Discounts	First Child	Second Child	Third Child
<b>Fee Total</b>	<b>\$5,300.00</b>	<b>\$5,000.00</b>	<b>\$4,700.00</b>
<b>10 Months</b>	<b>*\$530.00/month</b>	<b>*\$500.00/month</b>	<b>*\$470.00/month</b>

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

**Your child must be 5 by August 31<sup>st</sup>**

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

Weekly .....	1 <sup>st</sup> child \$70.00, 2 <sup>nd</sup> sibling \$60.00, 3 <sup>rd</sup> + sibling \$55.00
Weekly a.m. only.....	\$25.00
Weekly p.m. only.....	1 <sup>st</sup> child \$55.00, 2 <sup>nd</sup> sibling \$45.00
Daily Drop-Off a.m. & p.m.....	1 <sup>st</sup> child \$18.00, 2 <sup>nd</sup> 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 and an Assessment test.
- 5% discount on Tuition paid in full by July 31<sup>st</sup>.
- 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 1<sup>st</sup>, 5<sup>th</sup>, or 20<sup>th</sup> 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 8<sup>th</sup> grade. An online application is available through [online.factsmgmt.com](http://online.factsmgmt.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 31<sup>st</sup> h.***
- ***Multi-family discounts will be given to students Kindergarten – 8<sup>th</sup> 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)

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\*Parent//Guardian Name: (Please Print) \_\_\_\_\_

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

\*Parent//Guardian Name: (Please Print) \_\_\_\_\_

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

# 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<sup>1</sup> 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<sup>2</sup>:**

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

##### **GRADES 1-6:**

- DTaP/DTP:** 4 or more doses. If the 4<sup>th</sup> dose was prior to the 4<sup>th</sup> birthday, a 5<sup>th</sup> 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 3<sup>rd</sup> dose was prior to the 4<sup>th</sup> birthday, a 4<sup>th</sup> dose is required.
- MMR<sup>3</sup>:** 2 doses. The 1<sup>st</sup> dose should be given on or after the 1<sup>st</sup> birthday. The 2<sup>nd</sup> dose should be given after the 4<sup>th</sup> birthday.
- Hep B<sup>3</sup>:** 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- Varicella<sup>4</sup>:** 2 doses. The 1<sup>st</sup> dose must be given on or after the 1<sup>st</sup> birthday and the 2<sup>nd</sup> dose after the 4<sup>th</sup> 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

<sup>1</sup> Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3<sup>rd</sup> ed.) AAP, 2008

<sup>2</sup> Children who enter school prior to age four shall follow current Delaware Division of Public Health recommendations.

<sup>3</sup> Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.

<sup>4</sup> 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
	Yes	No	
Developmental delay (speech, ambulation, other)?			
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? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____	Yes	No	
Dental concerns? <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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**

**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

<b>Screen</b>	<b>Height:</b> _____ <b>Weight:</b> _____ <b>BMI:</b> _____ <b>BMI Percentile:</b> _____ <b>BP:</b> _____ <b>Pulse:</b> _____ <b>Other:</b> _____ (inches) (pounds)
<b>Dental Screen</b>	<input type="checkbox"/> <b>Problem Identified:</b> Referred for treatment <input type="checkbox"/> <b>No Problem:</b> Referred for prevention <input type="checkbox"/> <b>No Referral:</b> Already receiving dental care
<b>Tuberculosis Screen</b>	All new enterers must have TB test <u>or</u> TB Risk Assessment, which must be done within 12 months <u>prior</u> to school entry. <b>Risk Assessment:</b> _____ <b>Date</b> _____ <b>Results:</b> <input type="checkbox"/> Test Required <input type="checkbox"/> Test Not Required <b>Mantoux Skin Test:</b> _____ <b>Date</b> _____ <b>Results:</b> _____ MM <b>Other:</b> (type) _____ <b>Date</b> _____ <b>Results:</b> _____ MM
<b>Lead Test</b>	Blood lead test required for children age 6 months through 6 years <b>Date:</b> _____ <b>Results:</b> _____
<b>Other Screen</b>	<b>Hearing:</b> Type: _____ <b>Date:</b> _____ <b>Results:</b> _____ <b>Referral:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date <b>Vision:</b> Type: _____ <b>Date:</b> _____ <b>Results:</b> _____ <b>Referral:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date <b>Other:</b> Type: _____ <b>Date:</b> _____ <b>Results:</b> _____ <b>Referral:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date



**PART IV – COMPREHENSIVE EXAM**

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

PHYSICAL EXAMINATION	Check (✓)			HEALTHCARE PROVIDER COMMENT
	NORMAL	ABNORMAL	REFERRAL	
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:** \_\_\_\_\_



Date: \_\_\_\_\_

To: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Email: \_\_\_\_\_

RE: REQUEST FOR RECORDS

To Whom it May Concern:

The following student(s) has/have registered at Lighthouse Christian School:

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

*According to the Family Rights & Privacy Act (Buckley Amendment), it is no longer necessary to obtain written consent to release records between schools.*

Please forward all school records, together with medical records for the above students(s).

Lighthouse Christian School

Deborah A. O'Neal

doneal@lighthousechristianschool.com



## **Parental/Guardian Consent for Student Information**

Lighthouse Christian School has my permission to speak with my child's present/previous school concerning their grades, test scores, IEP's, 504 plans, & behavioral records as applicable for potential enrollment at Lighthouse Christian School.

Student Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

\*\*Information received will be provided to LCS Admissions Committee as part of the Registration process.



**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](http://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 \_\_\_\_\_