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1695 Discovery Falls Drive
Chula Vista. California 91915
619 656 8100 tel
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www.concordiachurch.com

CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM

RE-ENROLLMENT PACKET

This packet should be completed only if you are re-enrolling your child for the Before and After School Program. If you are new to the program, please return to the website and download the Before and After School Program Enrollment Packet.

State Requirements for Re-Enrollment
License #376701235

Check that all forms are completed and signed.

Completed	Description
	Application
	Electronic Payment Authorization
	Identification and Emergency Information (LIC 700)
	Consent for Emergency Medical Treatment (LIC 627)
	Classroom Emergency Information
	Medical History
	Parent's Contract for Admission of Students

Child's Name: _____ Date: _____
Last, First

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BEFORE/AFTER SCHOOL PROGRAM APPLICATION

License #376701235

Student Information

Child's Last Name	Child's First Name	Date of Birth (mm/dd/yyyy)
Child's Address		
City	State	Zip
Referred By		

Parent / Legal Guardian 1

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Cell Phone Number	Home Phone Number	Email Address
Employer		Work Phone Number

Parent / Legal Guardian 2

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Cell Phone Number	Home Phone Number	Email Address
Employer		Work Phone Number

There is no application fee for re-enrolling your child.

Please make check payable to Concordia Church and School. **Prices effective July 28, 2025**

Select Program Option	Program Days	Program Weekly Cost
☐ Before and After School	Monday through Friday	$170.00
☐ After School Only	Monday through Friday	$145.00

The following information will help us better serve you and your family.

Family Information

Are you active military? ☐Yes ☐No	Do you regularly attend a local church? ☐Yes ☐No
	Name of Pastor:

After completing the registration packet, return it to the School Office in person.

Thank you.

Rexanna Blas, Director
Michelle Schmidt, Director

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ELECTRONIC PAYMENT AUTHORIZATION

FOR OFFICE USE ONLY		
Date	Child Number	Child Name

☐ Preschool and Child Care Center	☐ Before and After School Program	☐ Intersession Program

Effective date of authorization (mm/dd/yyyy)

Type of authorization (check all that apply)

☐ New authorization ☐ Change payment amount ☐ Change payment date ☐ Change banking information ☐ Discontinue payment

Last Name	First Name

Address

City	State	Zip

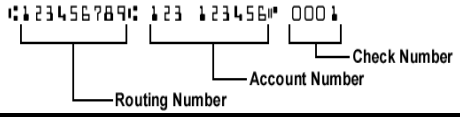
Primary Phone	Email

OFFICE USE ONLY			
Date of first payment (mm/dd/yyyy)	Amount of first payment $	Amount of ongoing payment $	Date of last payment - optional (mm/dd/yyyy)

Please debit payments from my (check one)	Routing Number	Account Number
☐ Savings Account (contact financial institution for Routing #)		
☐ Checking Account (attach a voided check below)		

Check Routing Number Example

A Valid Routing # must start with 0, 1, 2, or 3.



Weekly payments withdraw on Mondays.

I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature	Date

Please attach a voided check at the bottom of this page.

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS NUMBER	STREET	CITY	STATE ZIP	BIRTHDATE
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST		BUSINESS TELEPHONE ( )
HOME ADDRESS NUMBER	STREET	CITY	STATE ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Concordia Preschool and Child Care
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

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Before and After School Classroom Emergency Information

Student Information Today's Date:

Child's Last Name	Child's First Name	Date of Birth (mm/dd/yyyy)	Age

Does your child take any medication on a regular basis? ☐ Yes ☐ No

If yes, please list medication.

List any allergies or special needs your child has.

Is there anything else we should know about child?

Father / Legal Guardian 1

Last Name	First Name	Middle Initial	
Address	City	State	Zip
Cell Phone Number	Home Phone Number	Email Address	
Employer/Occupation	Work Phone Number		

Mother / Legal Guardian 2

Last Name	First Name	Middle Initial	
Address	City	State	Zip
Cell Phone Number	Home Phone Number	Email Address	
Employer/Occupation	Work Phone Number		

All People Who Are Authorized to Pick Up Other than Parents

Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship
Last Name	First Name	Phone	Relationship

Photo Release (check all that apply)

I give permission to use my child's photo for the following purpose:

☐ Promotional Materials ☐ Classroom Use (art projects, to hang in the classroom and the hall) ☐ None at this time

Official use only.

Classroom: _____

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Medical History

Child Information

Last Name	First Name	Date

Parent / Legal Guardian 1

Last Name	First Name	
Cell Phone Number	Home Phone Number	Work Phone Number

Parent / Legal Guardian 2

Last Name	First Name	
Cell Phone Number	Home Phone Number	Work Phone Number

Medical History

Please list your child's medical history including hernias, head injuries, heart disorders, cancer, arthritis, scoliosis, hearing/vision problems, learning difficulties, eating disorders, or other illnesses.
If pre-existing medical conditions may affect participation in daily activities, please have your doctor document these conditions and give approval or agree to discuss the condition with a Concordia School Director.

Parent/Legal Guardian Signature

Sign Full Name	Print Full Name	Date

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CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM
PARENTS' CONTRACT FOR ADMISSION OF STUDENTS

License #376700616

Parents/Legal Guardians with whom student lives

Father/Legal Guardian Last Name	Father/Legal Guardian First Name	Cell Phone	
Mother/Legal Guardian Last Name	Mother/Legal Guardian First Name	Cell Phone	
Address	City	State	Zip

Student Information

Last Name	First Name	Middle Initial	Date of Birth

By my signature on this document, I acknowledge that I am the parent or legal guardian of the above student for whom I have requested admission into the Before and After School Program.

BY RESOLUTION OF THE BOARD OF EDUCATION FOR THE CONCORDIA BEFORE AND AFTER SCHOOL PROGRAM (B/A), THE FOLLOWING STATEMENTS ARE DESIGNED TO BE THE CONDITIONS FOR ADMISSION: In consideration of such admission, I agree to the conditions governing admission and attendance at the B/A, as stated below.

I understand the annual application fee is to be paid in advance to secure my child's space for the schedule I need/desire and that this fee is nonrefundable.

I agree to make tuition and fee payments to the B/A on or before the scheduled dates. Tuition is due and payable each week by automatic electronic withdrawal from a checking or savings account. A $30.00 insufficient funds fee will be assessed for each payment not honored by the bank. I acknowledge that the B/A may enforce the following penalty: **The B/A may, at its sole option, terminate the enrollment of any student when payment of fees is in arrears and has not been received by the B/A within 30 days unless prior arrangements has been made with the Business Administrator.**

The administration reserves the right to adjust the prices of it programs at the beginning of each academic school year (or at any time deemed necessary); families will be informed of this change as students enroll for the upcoming school year or at least one month before the change takes effect.

I understand there is NO deduction in fees and "make-up" days are not allowed when my child is absent due to B/A closures, holidays, family vacations, or illness.

B/A hours are available from 6:30 am to 5:30 pm. I understand it is my responsibility to ensure my child is picked up every day by his/her assigned departure time. If not, I understand that I will be billed a late fee of $1.00 per child, per minute or fraction thereof. After three (3) late pick ups per quarter, the child may be put on probation pending a review of the circumstances. Abuse of this may cause the child to be expelled from the program.

I understand that I must give TWO (2) WEEKS WRITTEN NOTICE if my child will be leaving. If written notice is not given, I agree to pay for those two weeks.

Requests for schedule changes will be made in writing and are subject to space availability in the child's classroom. Schedule changes will take effect only at the beginning of a month.

I agree to read and adhere to the policies, procedures, rules, and regulations communicated by the B/A. Violations of the stated rules and regulations may result in expulsion from the B/A.

I agree to allow my child to participate in all B/A functions, including those that are worship related.

I understand that from time to time my child's class may walk along the school/church property or to the park bordering the school during school hours. I give permission for my child to participate with his/her class on such walks outside the classroom.

I understand that if my child's behavior is disruptive to the learning of other students or endangers the safety of other students, and attempts to correct the behavior have been unsuccessful, my child may be removed from the B/A program.

RIGHTS OF CHILD CARE LICENSING:

a. The Department has inspection authority to enter and inspect a facility without advance notice.
b. The Department has the authority to interview children or staff, and to inspect and audit child or Child Care Center records without prior consent.

I UNDERSTAND THAT THE DEPARTMENT OF SOCIAL SERVIES OR LICENSING AGENCY HAS THE AUTHORITY TO OBSERVE, INTERVIEW, AND HAVE MY CHILD(REN) PHYSICALLY EXAMINED AT ANY TIME WITHOUT PRIOR CONSENT. AUTHORITY CITED: SECTION 1596.81, HEALTH & SAFETY CODE.

THE LICENSEE SHALL MAKE PROVISIONS FOR PRIVATE INTERVIEWS WITH ANY CHILD(REN) OR ANY STAFF MEMBER AND FOR THE EXAMINATION OF ALL RECORDS RELATING TO THE OPERATION OF THE FACILITY.

THE DEPARTMENT OF LICENSING AGENCY SHALL HAVE THE AUTHORITY TO OBSERVE THE PHYSICAL CONDITION OF MY CHILD(REN), INCLUDING CONDITIONS WHICH COULD INDICATE ABUSE, NEGLECT OR INAPPROPRIATE PLACEMENT AND TO HAVE A LICENSED MEDICAL PROFESSIONAL PHYSICALLY EXAMINE MY CHILD(REN).

My signature below indicates that I fully understand and will abide by the conditions and terms of this contract.

Parent/Legal Guardian Signature

Sign Full Name	Print Full Name	Date

Parent/Legal Guardian Signature

Sign Full Name	Print Full Name	Date