Dear Parent(s),

We are excited and thankful that you have decided to reenroll your child(ren) at Faith Christian Academy. We are honored that you entrust your child(ren)'s academic future into our care. We are thankful to God for allowing us this opportunity and do not take it lightly. It is our heart's desire to provide your child(ren) with a strong academic curriculum and, at the same time, encourage and develop their spiritual walk with the Lord.

Attached are the forms that will need to be completed and turned in by February 25, 2025, along with your registration fee of $225 per student. The registration fee must accompany these forms in order to hold a space for your child(ren). We can accept cash or check for the registration fee(s). If paying by check, please **make checks payable to Church on the Rock**. If paying by cash, please submit the cash in a sealed envelope marked with FCA Registration Fee(s), your child(ren)'s name and the amount enclosed. We have included a checklist as a reference for the documents needed.

Please provide your documents and registration fee(s) in a sealed envelope to the school office, during school hours, Monday through Thursday from 8:30 am to 3:45 pm on or before February 25, 2025. If you are enrolling a first-time student along with your current student(s), please also complete the FCA Enrollment Packet for the first-time student, and we will review your application and will be in contact to setup an interview with you and the FCA staff in early to mid-March. Also, the new student will take an achievement test in mid to late March.

If you have any questions, please do not hesitate to contact me at the church office.

Again, we thank you for your trust and confidence in us to provide your child(ren) with a Christ-centered education and look forward to another great year.

Sincerely,

Katie Gonzales
Administrator
Faith Christian Academy

FCA Re-Enrollment Packet Checklist
2025-2026 School Year

STUDENT INFORMATION:

Student's Name: _____

_____ Current Family Registration

_____ Enrollment Contract

_____ Registration Fee

_____ Student Information Form

_____ Current Immunization Record (if Exemption Affidavit expired or shots are needed for school year)

_____ Vision and Hearing Screening (where applicable – see below)

_____ Scoliosis Screening (where applicable – see below)

_____ FCA Student Annual Waiver (with a copy of insurance)

_____ FCA First Aid Permit

_____ Authorization for Dispensing Medication (if applicable)

Health Care Records

- Vision and hearing screening:
  - All kindergarten, 1st, 3rd, 5th and 7th grade students must provide a Vision and Hearing Screening from their physician.
  - All first-time entrants through 12th grade must provide a Vision and Hearing Screening from their physician.
- Screening for abnormal spinal curvature:
  - Girls will be screened two times, once at age 10 (or fall semester of grade 5) and again at age 12 (or fall semester of grade 7).
  - Boys will be screened one time at age 13 or 14 (or fall semester of grade 8).

FCA Current Family Registration
2025-2026 School Year

This form is not meant to simply hold a place for your child(ren), it is a financial commitment. By signing this registration form you agree that you are making a commitment to enroll the below child(ren) in Faith Christian Academy for the 2025-2026 school year.

PLEASE PRINT WITH BLUE OR BLACK INK

KINDERGARTEN – 12TH GRADE

	STUDENT'S NAME	BIRTHDATE	GRADE (2025-2026)
1.			
2.			
3.			
4.			
5.			
6.			

Parent(s) or Guardian Signature:

Printed Name	*Signature*	*Date*
Printed Name	*Signature*	*Date*

Please sign and return this form and the Enrollment Contract with your registration fees by February 25, 2025, to reserve your place. Forms cannot be accepted without the registration fee and signed contract.

FCA Enrollment Contract
2025-2026 School Year

In consideration of the acceptance of this Enrollment Contract by FCA, the undersigned agrees to pay the required fees as specified below.

PLEASE PRINT WITH BLUE OR BLACK INK

KINDERGARTEN – 12TH GRADE

STUDENT'S NAME	GRADE	REG FEE DUE 2/25/25	PAYMENT PLAN A ONE PAYMENT NO BANK DRAFT DUE JUNE 5, 2025	PAYMENT PLAN B 12 MOS. PAYMENT BANK DRAFT JUNE 2025-MAY 2026

I understand that my commitment to pay will help facilitate the costs for salaries and school expenses. Therefore, by signing below, I agree to pay the registration fee and understand that the registration fee is non-refundable. I also agree to pay the full tuition per student, as stated above, whether I choose to withdraw my student from Faith Christian Academy anytime during the 2025-2026 school year.

Parent(s) or Guardian Signature:

Printed Name	*Signature*	*Date*
Printed Name	*Signature*	*Date*

FCA Office Use

Received By: _____ Date Received: _____

Amount Paid: _____ Payment Type: _____

Revised 012225

FCA Student Information Form
2025-2026 School Year

PLEASE PRINT WITH BLUE OR BLACK INK

STUDENT'S NAME:

First _____ Last _____ Middle _____

Preferred Name: _____ Male: ☐ Female: ☐

Birthdate: _____ / _____ / _____ Grade: _____

FAMILY INFORMATION:

Full Name of Parent(s)/Legal Guardian(s) Student Lives With:

_____ ☐ Father ☐ Mother ☐ Guardian ☐ Stepparent

_____ ☐ Father ☐ Mother ☐ Guardian ☐ Stepparent

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Internet Available at Home: ☐ Yes ☐ No Preferred Method of Contact: _____

List All Siblings in Your Home (Include Non-School Age Children):

_____ Grade: _____ Birthdate: _____ / _____ / _____

_____ Grade: _____ Birthdate: _____ / _____ / _____

_____ Grade: _____ Birthdate: _____ / _____ / _____

_____ Grade: _____ Birthdate: _____ / _____ / _____

_____ Grade: _____ Birthdate: _____ / _____ / _____

_____ Grade: _____ Birthdate: _____ / _____ / _____

EMERGENCY CONTACTS:

Please provide the information below for three emergency contacts that have permission to assume temporary care of your child if you cannot be reached:

First _____ Last _____ Middle _____

PLEASE PRINT WITH BLUE OR BLACK INK

Mailing Address | City | State | Zip Code

Home Phone | Cell Phone | Email

First | Last | Middle

Mailing Address | City | State | Zip Code

Home Phone | Cell Phone | Email

First | Last | Middle

Mailing Address | City | State | Zip Code

Home Phone | Cell Phone | Email

☐ Check here if these people have permission to drop-off and pick-up your child at/from school.

MEDICAL INFORMATION:

For educational purposes, I wish to share the following information with Faith Christian Academy Staff:

Health Conditions: _____

Allergies: _____

Medications: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician/dentist below and to follow his/her instructions. If it is impossible to contact this physician/dentist, the school may make whatever medical arrangements they deem necessary.

Parent/Guardian Signature: _____

Name of Physician: _____ Office Phone: _____

Name of Dentist: _____ Office Phone: _____

FCA Health Form
2025-2026 School Year

925 Golden Oaks Road, Georgetown, Texas 78628
(512) 864-7713

PLEASE PRINT WITH BLUE OR BLACK INK

STUDENT'S NAME:

First _____ Last _____ Middle _____

Birthdate: _____ / _____ / _____

Parent/Guardian Printed Name _____ Parent/Guardian Signature _____

Physician's Name: _____ Telephone Number: _____

Physician's Address: _____

1. **HEARING AND VISION SCREENING.** If your child is 4 or over by September 1, the State of Texas requires that each child be given hearing and vision screenings – with the results in numeric form. Parents have the option of asking a private physician or health professional perform the testing.

HZ	1000	2000	4000
Right Ear:			
Left Ear:			

Pass: _____ Fail: _____

Right Eye:	20/	Left Eye:	20/

Pass: _____ Fail: _____

2. **SPINAL SCREENING.** Texas State Law requires spinal screening for 5th and 8th grade students. As a part of this student's physical, please include an exam for spinal disorders, including scoliosis, kyphosis, and lordosis.

_____ Spinal Exam, including forward bend test, within normal limits

_____ Follow-up indicated

COMMENTS/RECOMMENDATIONS/RESTRICTIONS FOR THE SCHOOL SETTING:

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

FCA Student Annual Waiver
2025-2026 School Year

By signing below, I, _____ testify that I am the parent/legal guardian of the the student(s) listed below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

and hereby declare that permission/consent has been granted for my student(s) and/or custodial minor(s) to attend and participate in any events for the 2025-2026 school year with Faith Christian Academy. I understand what duties, responsibilities and tasks are required to participate in these events. I declare that my student(s) is/are physically and mentally able and competent to participate in these events. I also hereby release the officers, employees, agents, or representatives of Faith Christian Academy and Church on the Rock, Georgetown from any and/or all liability associated with these events. I authorize the officers, employees, agents, or representatives to make decisions for any and all medical attention my student(s) may require while in the care of said officers, employees, agents, or representatives. I have been given an opportunity to submit below any known medical conditions and allergies for my student(s); as well as all activities that I wish my student(s) not participate in. If there are any changes in medical, emergency contact and/or insurance information as well as any activities I do not want my student(s) to participate in, I understand it is my responsibility to inform the officers, employees, agents, or representatives prior to each event by submitting an *FCA Annual Waiver Change Form*. I understand that events are subject to change and by signing this document, I agree to these terms for updated events as well. I understand that by signing the *FCA Student Annual Waiver Form*, I am not committing my student(s) to attend all Faith Christian Academy events and that I am responsible to confirm their participation for each event for planning purposes.

I understand that if a student, parent, teacher, assistant, or substitute of Faith Christian Academy or individual that attends Church on the Rock organizes an activity or event that is not on the Faith Christian Academy or Church on the Rock calendar or does not have an email sent from the FCA Administrator, it has not been authorized by Faith Christian Academy or Church on the Rock and is not a school or church-sponsored activity or event. I also understand that this form, as well as the Faith Christian Academy and Church on the Rock Guidelines and Procedures, would not apply to this activity or event and all responsibility and liability would fall solely on the individual organizing the activity or event.

MEDICAL INFORMATION:

List each student individually and list any allergies and/or medical conditions pertaining to each student. If there are no allergies and/or medical conditions, write N/A.

STUDENT'S NAME	ALLERGIES	MEDICAL CONDITION

EXCLUDED ACTIVITIES:

List any activities, per student if applicable, that you DO NOT want your student(s) participating in:

_____

_____

EMERGENCY CONTACT (REQUIRED):

_____	_____	_____
Printed Name	*Relationship*	*Phone Number*

INSURANCE:

Do you have medical insurance? (If yes, a copy of your card is required.) ☐ Yes ☐ No

Signed this Day: _____ Month: _____ Year: _____

_____	_____	_____
Printed Name	*Signature*	*Relationship to Student*

FCA First Aid Permit
2025-2026 School Year

By signing below, I, _____ testify that I am the legal parent/guardian of the child(ren) listed below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

and I authorize the officers, employees, agents, or representatives to make decisions for any and all medical attention my child(ren) may require while in the care of said officers, employees, agents, or representatives. I have been given an opportunity below to submit any known medical conditions and allergies for my children. If there are any changes in medical and emergency contact information, I understand it is my responsibility to inform the officers, employees, agents, or representatives and update the school office.

FIRST AID CARE:

List each child individually and circle Yes or No for each first aid item. If you choose no, please indicate your preference for treatment.

CHILD'S NAME	BANDAGE/ GAUZE	COLD PACK	ANTIBIOTIC CREAM	ANTI-ITCH CREAM	ALCOHOL SWAB	PREFERENCE
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	

List each child individually and list any allergies and/or medical conditions pertaining to each child. If there are no allergies and/or medical conditions, write N/A.

CHILD'S NAME	ALLERGIES	MEDICAL CONDITION

Parent/Guardian's Signature:

_____ _____ _____

Printed Name *Signature* *Date*

FCA Authorization for Dispensing Medication
2025-2026 School Year

PARENT'S AUTHORIZATION:

By signing below, I authorize the officers, employees, agents, or representatives of Faith Christian Academy to dispense the following medication to my child. The medication must be in its original container and labeled with the child's name and the date medication was provided to the school. Medication can only be administered in the amount stated in the label directions.

Child's Name: ______________________________

Parent/Guardian's Signature:

Printed Name	*Signature*	*Date*

MEDICATION:

Medication to be Dispensed:					
Time(s) to be Administered:			Dosage:		
Period of Time to be Administered:		(date)	to		(date)
Possible Side Effects:					
Reason for Medication:					
Prescribing Physician:					
Physician Phone Number:					

MEDICATION:

Medication to be Dispensed:					
Time(s) to be Administered:			Dosage:		
Period of Time to be Administered:		(date)	to		(date)
Possible Side Effects:					
Reason for Medication:					
Prescribing Physician:					
Physician Phone Number:					

MEDICATION:

Medication to be Dispensed:					
Time(s) to be Administered:			Dosage:		
Period of Time to be Administered:		(date)	to		(date)
Possible Side Effects:					
Reason for Medication:					
Prescribing Physician:					
Physician Phone Number:					