

ADMISSION APPLICATION

2023-2024

FIRST STUDENT'S PERSONAL INFORMATION (for additional students, see next page)

Date of Application:		Applying for (Grade):	
First Name:	Middle Name:	Last Name:	
Date of Birth:	Sex:	Male	Female
City & State of Birth:	Country of Birth:		
Street Address:			
P.O. Box, if any			
City:	State:	Zip Code:	
Home Telephone:			

STUDENT'S FAMILY INFORMATION

MOTHER OR LEGAL FEMALE GUARDIAN	FATHER OR LEGAL MALE GUARDIAN
Name:	Name:
Relationship to Student:	Relationship to Student:
<input type="checkbox"/> Check here if address is same as above student's	<input type="checkbox"/> Check here if address is same as above student's
Address:	Address:
City/State:	City/State:
Zip Code:	Zip Code:
Email:	Email:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Does the student reside at this address? Y N	Does the student reside at this address: Y N
Is there shared custody of this child? Y N	Is there shared custody of this child: Y N

It is required that we have your legal physical address on file. If your physical address is different from the one listed above, please provide the following:

Physical Address: _____ City: _____ State: _____ Zip: _____

TRANSFER INFORMATION (IF APPLICABLE)

Please list other schools attended: (If it's not applicable, note with N/A)			
Years attended:		Years attended:	
Name of School:		Name of School:	
Mailing Address:		Mailing Address:	
Phone #	Fax #	Phone #	Fax #
Email address:		Email address:	

TRANSFER STUDENT'S PARENT/GUARDIAN MUST SIGN THE RELEASE OF TRANSCRIPTS FORM BEFORE ADMISSION

ADMISSION APPLICATION

2023-2024

SECOND STUDENT'S PERSONAL INFORMATION			
Date of Application:		Applying for (Grade):	
First Name:	Middle Name:	Last Name:	
Date of Birth:	Sex:	Male	Female
City & State of Birth:		Country of Birth:	
Street Address:			
P.O. Box, if any			
City:	State:	Zip Code:	
Home Telephone:			

THIRD STUDENT'S PERSONAL INFORMATION:			
Date of Application:		Applying for (Grade):	
First Name:	Middle Name:	Last Name:	
Date of Birth:	Sex:	Male	Female
City & State of Birth:		Country of Birth:	
Street Address:			
P.O. Box, if any			
City:	State:	Zip Code:	
Home Telephone:			

FOURTH STUDENT'S PERSONAL INFORMATION:			
Date of Application:		Applying for (Grade):	
First Name:	Middle Name:	Last Name:	
Date of Birth:	Sex:	Male	Female
City & State of Birth:		Country of Birth:	
Street Address:			
P.O. Box, if any			
City:	State:	Zip Code:	
Home Telephone:			

FINANCIAL AGREEMENT 2023-2024



First Child's Name: _____ Grade Entering: _____
Second Child's Name: _____ Grade Entering: _____
Third Child's Name: _____ Grade Entering: _____
Fourth Child's Name: _____ Grade Entering: _____

I. REGISTRATION FEE:

Returning Students	\$25.00 (per child)*	\$ _____
New Students	\$50.00 (per child)*	\$ _____

II. BOOK FEE: \$300.00 (per child) \$ _____

TOTAL REGISTRATION AND BOOK FEE: \$ _____

III. TUITION RATES:

First Child: \$3,575 per year
Second Child: \$2,860 per year (20% discount)
Third Child: \$2,500 per year (30% discount)
Fourth Child: \$2,145 per year (40% discount)

IV. TUITION PAYMENTS: Payments are due on the 15th of each month. There are two payment options: a 10 month payment plan beginning on August 15th and ending on May 15th or an 11 month payment plan beginning on July 15th and ending on May 15th.

***Non refundable**

I, (please print name) _____ (parent/legal guardian/agent) certify that I assume full responsibility for payment of all tuition and fees to Machias Valley Christian School for the aforementioned student's program of study.

Signature

Date

TUITION AND FEES PAYMENT POLICY

Enrollment, Tuition, and Fees Payment Policy

Prompt payment of tuition and fees is required of all families and is an essential part of having your child enrolled in a private school. Machias Valley Christian is a small institution and relies on prompt, full payment of all tuition and fees in order to operate.

Payment of registration, tuition, and book fees:

Registration and books fees must be paid at the time of registration. Tuition, less any stated financial aid, must be paid to MVCS in advance, either up-front for the whole school year, or divided into 10 or 11 equal monthly installments payable monthly beginning in July (11 month plan) or August (10 month plan), with payments due on the 15th of each month. Please be advised that a late fee of \$5.00 will be applied per month if not paid before the due date.

Collection Policy:

An excess of three (3) late or incomplete payments during the course of a given school year without prior approval by the Board, or any late or incomplete payment in excess of thirty (30) days, will constitute a breach of the registration agreement and conditions of enrollment. In such a situation, notice will be provided in writing by MVCS that the account is in arrears and that full payment must be made within 15 days of notification, or enrollment of the family's child may terminate at the end of the 15 day notification period. The family will remain liable for all normal tuition, fees and pledges through to the next calendar month.

Legal Collection:

MVCS may use any legal means at its disposal to reclaim funds past due, including the engagement of third-party collection agencies to whom financial details will be passed by MVCS as is permissible by law and through small claims court.

Withholding of grades, report cards and transcripts:

Any payments outstanding at the end of a grading period (whether of tuition and fees, lunch fees, or any other fees owed to MVCS) may result in withholding of student academic records until full payment is received of all outstanding balances. Medical records will be released immediately upon request. Participation in graduation may be denied.

Early withdrawal of students / termination of enrollment:

Registration of students at MVCS is for a full school year, as indicated on the application and registration forms. MVCS operates on a tight budget, made possible by knowing that it will receive payment for all its enrolled students over the full course of each academic year.

If a parent or family elects to un-enroll or withdraw their child from MVCS during an active school year, MVCS requires two (2) months' notice of this intention, and the parent or family remains responsible for the prompt payment of full tuition and fees. Should the child be physically withdrawn from MVCS by the parents prior to the term of this two-month notice period, full payment will still be required for the two month period, irrespective of the child's presence on campus or in class. (See next page.)

TUITION AND FEES PAYMENT POLICY



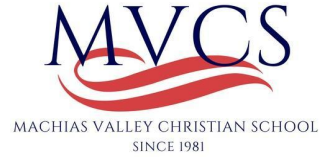
If a child's enrollment is terminated by MVCS for reasons of behavior or an infraction of school rules, policies, practices or standards, the parent or family of the child remains liable for full payment of all tuition and fees through to the end of billing month in which the enrollment was terminated, irrespective of whether the child is allowed to remain on campus or in classes.

Enrollment for the next school year may be denied unless a student's/family's account is paid in full.

Parent Signature:

Date:

PERMISSION TO ADMINISTER MEDICAL TREATMENT AND MEDICATIONS IN SCHOOL 2023-2024



MVCS encourages all students to take needed medications—either over-the-counter or prescription—at home, before or after school. We do recognize, however, that students occasionally need to receive medicine or medical treatment during school hours. Therefore, with the goal of maintaining wellness and decreasing student absenteeism, it is necessary that this form be completed in full and returned to the school office no later than the first day of school.

STUDENT'S NAME: _____ DOB: _____

To be completed by Parent/Guardian

I am aware MVCS has no regularly available medical personnel on staff; however, I give permission to MVCS staff, unlicensed but appropriately trained, to **administer medical treatment and give medication necessary to my child** in the event of an accident, injury, sickness, etc., during the school year. This includes all events, trips, activities, etc., in which my child may participate. I certify that I have legal authority to give consent for my child's medical treatment. In addition, I give permission for the MVCS School Nurse to communicate with our Health Care Provider as allowed by HIPAA regulations.

Parent's Names: _____

Home Address (street/city/zip): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Family Physician _____ Phone #: _____

Student's Known Allergies: _____

In the event of an emergency, if I cannot be reached, I designate the following people to act as my agents:

Name: _____ Phone # _____

Name: _____ Phone # _____

I hereby release, discharge, and agree to hold harmless Machias Valley Christian School their officers, Board members, Administrators, teachers, aides, secretaries, volunteers (and their heirs, administrators or assigns) from any and all claims, damages, demands, actions, judgments, and execution of any nature or description that may arise out of the administration of medication or medical treatment.

Parent/Guardian Signature _____ Date: _____

PERMISSION TO ADMINISTER MEDICAL TREATMENT AND MEDICATIONS IN SCHOOL 2023-2024



CONCUSSION AND HEAD INJURY CARE

To be reviewed completed by parent/guardian and student

Because of the recent awareness of the seriousness of concussions and other head injuries, MVCS has adopted a procedure policy to address these injuries and promote the safety of our students. This policy is available in the School Office and includes a detailed concussion information sheet.

Therefore, in accordance with this policy, we are requesting you and your student review in detail the attached United States Department of Health & Human Services Centers for Disease Control & Prevention **“Fact Sheet for Parents - Know your Concussion ABC’s”**, see next page.

I, parent/guardian of (student’s name) _____, have received, reviewed, and understand the CDC Concussion Fact Sheet For Parents.

With this understanding, I agree to allow the above named student to participate in all MVCS school activities and programs.

Signature of Parent/Guardian: _____ Date: _____

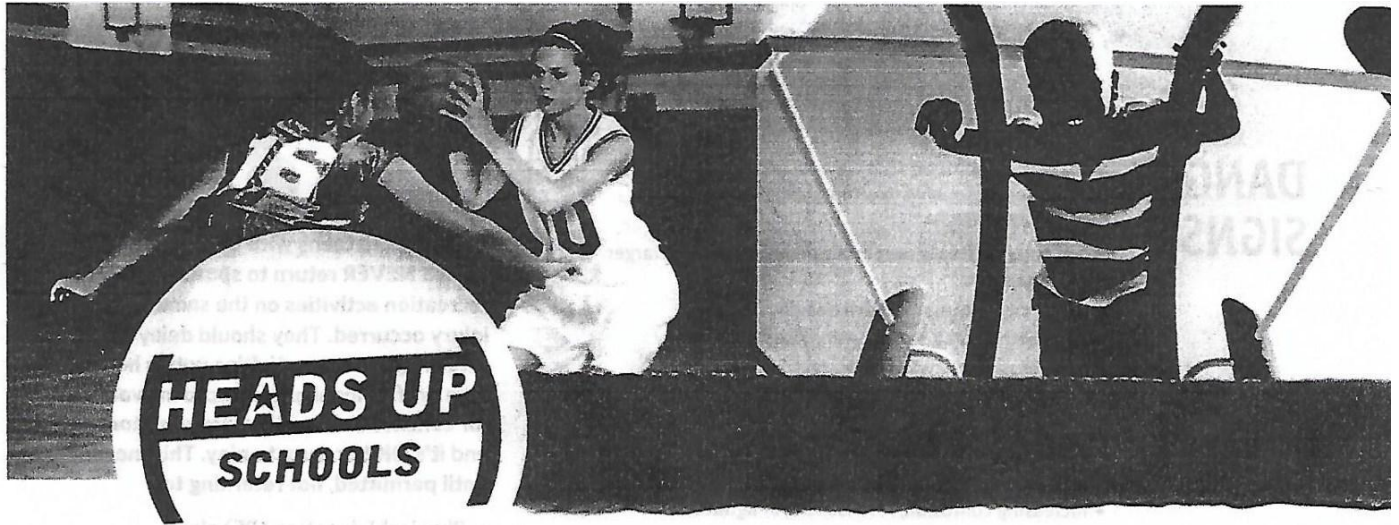
I, (student’s name) _____ have received and reviewed the CDC Concussion Fact Sheet and agree to inform MVCS staff of any head injury I receive while participating in school activities and programs.

Signature of Student: _____ Date: _____

PERMISSION TO ADMINISTER MEDICAL TREATMENT AND MEDICATIONS IN SCHOOL 2023-2024



MACHIAS VALLEY CHRISTIAN SCHOOL
SINCE 1981



What is a concussion?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious.

Concussions can have a more serious effect on a young, developing brain and need to be addressed correctly.

What are the signs and symptoms of a concussion?

You can't see a concussion. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how your child or teen is acting or feeling, if symptoms are getting worse, or if s/he just "doesn't feel right." Most concussions occur without loss of consciousness.

If your child or teen reports *one or more* of the symptoms of concussion listed below, or if you notice the symptoms yourself, seek medical attention right away. Children and teens are among those at greatest risk for concussion.

SIGNS AND SYMPTOMS OF A CONCUSSION	
<p>SIGNS OBSERVED BY PARENTS OR GUARDIANS</p> <ul style="list-style-type: none"> • Appears dazed or stunned • Is confused about events • Answers questions slowly • Repeats questions • Can't recall events <i>prior</i> to the hit, bump, or fall • Can't recall events <i>after</i> the hit, bump, or fall • Loses consciousness (even briefly) • Shows behavior or personality changes • Forgets class schedule or assignments 	<p>SYMPTOMS REPORTED BY YOUR CHILD OR TEEN</p> <p>Thinking/Remembering:</p> <ul style="list-style-type: none"> • Difficulty thinking clearly • Difficulty concentrating or remembering • Feeling more slowed down • Feeling sluggish, hazy, foggy, or groggy <p>Physical:</p> <ul style="list-style-type: none"> • Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Fatigue or feeling tired • Blurry or double vision • Sensitivity to light or noise • Numbness or tingling • Does not "feel right" <p>Emotional:</p> <ul style="list-style-type: none"> • Irritable • Sad • More emotional than usual • Nervous <p>Sleep*:</p> <ul style="list-style-type: none"> • Drowsy • Sleeps <i>less</i> than usual • Sleeps <i>more</i> than usual • Has trouble falling asleep <p><i>*Only ask about sleep symptoms if the injury occurred on a prior day.</i></p>

To download this fact sheet in Spanish, please visit: www.cdc.gov/Concussion. Para obtener una copia electrónica de esta hoja de información en español, por favor visite: www.cdc.gov/Concussion.



PERMISSION TO ADMINISTER MEDICAL TREATMENT AND MEDICATIONS IN SCHOOL 2023-2024



STUDENT'S NAME: _____ DOB: _____ GRADE: _____

Dear Parent/Guardian:

There are times during the school day when your son/daughter may come to the School Office with a headache, upset stomach, or other pain issue. With the written permission form (page 1) from you, they may receive OTC (over-the-counter) medication to relieve their symptoms and allow them to have a successful school day.

Our school physician, Alf Wakeman, PAC, of Eastport Healthcare, has provided standing orders and protocols for the medications listed below. The dosages of medications are based on a standardized average of weights of children in Grades K-6. If you would prefer a different dosage of medication, we would require a different order from your primary care provider. If you would like your child to receive any of these medications at school, please indicate your preferences below and sign this form giving consent. If you would prefer that your child NOT receive OTC medication at school, please indicate below and also sign this form. No medications will then be dispensed if your child exhibits a fever or signs of an illness or condition that warrants dismissal from school. Other pain relief methods such as ice/hot packs, relaxation and breathing techniques, and hydration/snack will be used.

List **ALL medications** your child takes on a daily or on an occasional basis, including supplements: _____

Medical conditions: _____

Allergies: _____

My child has permission to receive the medication(s) checked below. I understand this medication will be given only after the school staff has made an assessment and determines it is appropriate and necessary.

- Acetaminophen: given per body weight every 4-6 hours as needed for minor pain/general discomfort
- Ibuprofen: given per body weight every 6 hours as needed for minor pain, inflammation, or general discomfort
- Cough drop/throat lozenges (for sore throat/cough): give 1 every 4 hours
- Tums (for upset stomach): give 1 chewable tablet every 4 hours
- Triple antibiotic ointment: Apply to minor cuts and abrasions after cleansing with soap and water. Cover with sterile dressing or band-aid, as needed.
- Benadryl (This oral medication will be given for hives or ACUTE allergic reaction ONLY.) Given per body weight every 4-6 hours as needed for hives or allergic reaction.

I would like to be informed when my child receives medication.

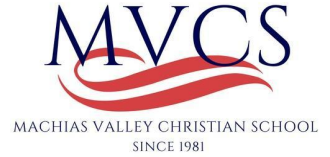
I DO NOT want my child to receive any OTC medications at school.

Parent/Guardian Name (printed): _____

Signature: _____ Date: _____

MVCS School Physician: SIGNATURE ON FILE MVCS School Nurse: SIGNATURE ON FILE
Alf Wakeman, PAC Laurie Curtis, LPN

PERMISSION TO ADMINISTER MEDICAL TREATMENT AND MEDICATIONS IN SCHOOL 2023-2024



SELF-ADMINISTERED MEDICATIONS

(To be completed only if Applicable)

Machias Valley Christian School recognizes that occasionally a student may wish to carry and self-administer medications for important reasons. However, it is our policy that **no student will carry and self-administer medications unless:**

The student has been specifically identified and authorized to do so in writing by the parent/guardian, and The student has been evaluated and deemed capable/responsible for carrying/self-administering medication by his/her Health Care Provider.

NOTE: Permission to carry/self-administer medications may be **REVOKED** at any time if the student is found to be endangering themselves or others in any way.

STUDENT'S NAME: _____ DOB: _____ GRADE: _____

The above named student has been evaluated and deemed capable/responsible of carrying/self-administering (name of medication): _____ by his/her Health Care

Provider (Circle One): Yes No

School Nurse approves this student carrying/self-administering medication (Circle One): Yes No

Initials: _____ Date: _____

We hereby agree to follow all procedures outlined above regarding any medications self-carried/self-administered, including notifying the School Office.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

MEDIA RELEASE FORM



FOR THE 2023-2024 SCHOOL YEAR

I, _____, hereby grant to Machias Valley Christian School, its agents and associates, unlimited use of school related video and photographs of my son/daughter _____, for use in school related publications, posters, manuscripts, and press releases.

Signature of Parent/Guardian

Date