



920 County Road 468 Leesburg, FL 34748

PHONE: 352-787-7100 FAX: 352-787-7110

2025-2026 Student Enrollment



OUR MISSION: *Our mission is to provide students with exceptional needs intensive, collaborative, classroom-based educational and therapeutic interventions to promote independence and academic success.*

OUR VISION: *At Kerrington's Care Academy, Inc, we envision a nurturing and inclusive educational environment where students with exceptional needs are empowered to reach their full potential. Our commitment is to foster a community of support, understanding, and excellence, where every student is given the tools and opportunities to thrive academically, socially, and emotionally. Through individualized instruction, innovative teaching practices, and a holistic approach to development, we aim to inspire confidence, independence, and lifelong learning in our students, preparing them to lead fulfilling and meaningful lives.*

Latisha Ward-Williams, Principal

Kerrington's Care Academy Creed:

I AM A BRIGHT AND UNIQUE MEMBER OF MY SCHOOL AND
COMMUNITY.

I AM HERE TO BE THE BEST THAT I CAN BE.

I AM RESPONSIBLE FOR MY OWN DESTINY, CONTROLLED
BY THE CHOICES I MAKE.

I DO NOT HAVE THE RIGHT TO HINDER OTHERS FROM LEARNING, AND THEY
CANNOT HINDER ME.

I LEARN FROM MY MISTAKES, I EMBRACE THEM, STRIVING EVERYDAY TO BE A
BETTER ME. UNDERSTANDING THAT I CAN LEARN.

I JUST LEARN DIFFERENTLY!

"We Learn Differently "



Application Date: _____ **Entering Grade:** _____

Student Information

Child's Name: _____
(Last Name) (First Name) (Middle Name)

Social Security Number: _____ - _____ - _____ **DOB:** ____/____/____ **Sex:** M F

Current Address:

(Address) (City) (State) (Zip Code)

Race: Yes, Hispanic or Latino No – Not Hispanic or Latino

Ethnicity: American Indian Asian Black Hispanic Caucasian(White)

Other: _____

Place of Birth: _____ **Primary Language:** _____
(City) (State)

Student Scholarship:

- ☐ Step Up for Students
- ☐ New Worlds Scholarship (VPK)
- ☐ The Family Empowerment Scholarship for Educational Options (FES-UA) Unique Abilities
- ☐ The Florida Tax Credit Scholarship (FTC, FES, EO)
- ☐ Hope Scholarship
- ☐ Reading Scholarship
- ☐ None Other: _____

Parent/Guardian Information

Primary Parent/Guardian Name with legal authority over the student

Name: _____ **Relationship:** _____

Social Security Number: _____ - _____ - _____

Home Phone: (_____) _____ - _____ **Cell Phone:**(_____) _____ - _____

Email: _____

Address (if different from student): _____

Parents Marital Status (circle)

Married Separated Divorced Single

Does any other parent/guardian have legal custody/authority over this student? ☐No ☐Yes

If Yes: Name: _____ **Relationship:** _____

Social Security Number: _____ - _____ - _____

PREVIOUS SCHOOL

Name of last School Attended: _____

Address of Last School: _____

City/State/Zip: _____ **Telephone:** _____

Date Enrolled: _____ **Date Withdrawn:** _____

Last Date of Attendance: _____

I _____ attest that all information on this form and in the enclosed enrollment application is accurate. In addition, I also agree that I will be financially responsible for the above student's fees, tuition, or any other financial obligation that is incurred

Parent/Guardian Signature

Parent/Guardian Name (Printed):

Contact Information

Parent Guardian Please complete the following:

	Father	Mother
Name		
Home Phone		
Cell Phone		
Email		
Employer		
Work Phone		
Address (if different from student)		

Emergency Contact Information

All persons authorized to pick up students **MUST** show valid photo identification

Name: _____ **Relationship:** _____
Phone: (____) _____ **Authorized to pick up:** ☐ No ☐
Yes

Name: _____ **Relationship:** _____
Phone: (____) _____ **Authorized to pick up:** ☐ No ☐
Yes

Name: _____ **Relationship:** _____
Phone: (____) _____ **Authorized to pick up:** ☐ No ☐
Yes

Name: _____ **Relationship:** _____
Phone: (____) _____ **Authorized to pick up:** ☐ No ☐
Yes

Name: _____ **Relationship:** _____

Phone: (____) _____ Authorized to pick up: ☐ No ☐
Yes

Name: _____ Relationship: _____
Phone: (____) _____ Authorized to pick up: ☐ No ☐
Yes



**Kerrington's Care Academy
Parent Questionnaire**

Dear Parent:

In order to help us serve you and your family as effectively as possible, please fill out the questions below. All responses collected on this form and the Enrollment Application will be treated confidentially.

If you answer yes to any of the following four questions, please include a brief explanation in the space below the question.

1. Does the student have any disabilities that might limit his/her participation in class activities or that might affect his/her academic progress?

☐ Yes ☐ No

If yes, what is the disability? _____

Does the student have an IEP? _____

Does the student take medication? (CIRCLE ONE) YES NO

If yes, what is the medication? How often is it taken? _____

Additional Notes: _____

2. Does the student have any known allergies?

☐ No ☐ Yes: _____

3. Has the child ever had any serious disciplinary problems in school?

☐ No ☐ Yes: _____

4. Has the student ever had any criminal charges filed against him/her? If yes, please list in space available

☐ No ☐ Yes: _____

Disposition (outcome): _____

Is the student currently on probation/parole?

☐ No ☐ Yes: Officer's Name: _____

Additional Notes:

5. Does the student have a professional counselor? (CIRCLE ONE) YES NO

If yes, Name and Phone: _____

How often do they meet? _____

Is there anything the school needs to be aware of in regards to counselor involvement at school?

☐ No ☐ Yes: _____

6. Has the student ever been retained?

☐ No ☐ Yes: _____

7. How did you learn about Kerrington Care Academy? _____

8. What led you to decide to send your child to Kerrington Care Academy? _____

9. As a parent, what values are important to you when selecting a school?

10. Choose the scenario(s) that best describes your students learning style: (CIRCLE ALL THAT APPLY)

- When learning new information your student learns best when stating the situation out loud then reasoning through the solutions out loud.
- When in a classroom setting your student learns best if sitting in front of the classroom taking notes.
- Your student learns best when using visual analogies and photographs.

- Your student learns best when involved in a study group.
- Your student learns best with flashcards and visual metaphors.
- Your student learns best when using a computer to reinforce their sense of touch.

11. Is there any information that your child's teacher should be aware of? _____

TRANSPORTATION INFORMATION FORM

STUDENT NAME: _____

My child will:

☐ KCA transportation (Only if Available) ☐ Use family transportation ☐ Walk to school

If more than one option is selected, please explain:

Students for regular day classes should not arrive before 7:00am.

After 8:30 am, students are tardy and are required to obtain a tardy slip in order to enter class.

The school day ends at 3:00 pm at KCA . Each child must be picked up by 3:00 pm daily, unless they are enrolled in the After School Program.

If a child is not picked up by 3:00pm, a \$15 Late Pick Up fee will be issued. An additional \$15 fee will be issued for every 15 minutes thereafter.

If transportation changes are necessary it must be done before 2:00 pm (M-TUE-THR, F.)WED (early release 2:00pm)11:AM PM **Initial Here:** _____

Parents must notify the School Office, either by telephone or with a signed note, of any temporary changes to Transportation. For permanent changes, please submit another Transportation Information Form.

Initial Here: _____

Kerrington Care Academy ADMITS STUDENTS OF ANY RACE, COLOR, SEX, AGE, HANDICAP OR NATIONAL ETHNIC ORIGIN. ADMISSIONS TO THE SCHOOL ARE NOT BASED ON THE RELIGIOUS AFFILIATION OF THE CHILD.

Please sign and date: _____

Signature of Parent or Legal Guardian: _____

Date: _____

Print Name: _____

Please complete if your child is in grade 6-12th

Dream |Plan| Action

Student Name: _____

Grade/Teacher: _____

Please answer the following questions:

1. What are your plans for the future? _____
2. Which college/technical or vocational school would you like to attend when you graduate?
? _____
3. Do you feel you could succeed in college? (Circle One) YES NO
Why or Why not?

4. Are you interested in any of the following: (CIRCLE ALL THAT APPLY)
Owning your own business Construction Being in politics Sports Medicine
Cosmetology Military Culinary Fashion Design Automotive Repair
5. What other career interests you?

6. If you could do one thing with nothing holding you back what would it be?

7. Have you seen anyone doing what you want career-wise?

8. Do you feel like anything is holding you back from achieving your dreams?

If yes, who or what? _____

Demographic Information

Disclaimer: The following information will be used for the sole purpose of demographics and will not be used in the selection process of students

Student Name: _____ Date: _____

Student lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Extended Family

Household Size: # of Adults: _____ # of Children: _____

Household Annual Income:

_____ Less than \$10, 000

_____ \$10,000-20,000

_____ \$20,001-30,000

_____ \$30,001-40,000

_____ \$40,001-50,000

Source of Income: ☐ SSI BENEFITS ☐ TANF ☐ UNEMPLOYMENT ☐ OTHER

Is the student a parent? ☐ Yes ☐ No

If yes, ages of children: _____

Does he/she have custody? ☐ Yes ☐ No

Kerrington Care Academy
Student Emergency Medical Form

Insurance Information

Student Name: _____

Grade: _____

Parent's Name: _____

Day Phone Number: _____

Company #1: _____

Phone Number: _____

Preferred Doctor: _____

Phone Number: _____

Preferred Dentist: _____

Phone Number: _____

Preferred Hospital: _____

Phone Number: _____

(Responding medical unit will make the final determination as to the appropriate facility for the injury) **IF I AM UNABLE TO BE REACHED, PLEASE CONTACT ONE OF THE FOLLOWING PEOPLE AND TELL THEM OF MY CHILD'S CONDITION. THEY HAVE PERMISSION TO REMOVE MY CHILD FROM SCHOOL.**

Name: _____

Relationship to child: _____

Work Number: _____

Home Phone Number: _____

Name: _____

Relationship to child Work Number: _____

Home Phone Number: _____

Parent Signature: _____

Date: _____

Print Name: _____

Kerrington Care Academy

School Health Service Consent Form

I hereby give consent for this child to participate in the School Service Program. This means my child will receive emergency care in school, if needed, and health appraisals at school, including screening such as vision, hearing, growth, and development.

In case of an accident or illness where treatment is not needed, but where my child is unable to remain at school, I request the school to contact me. If I am unable to be reached, one of the persons listed on the Student Emergency Medical Form may be contacted to care for my child until I can be reached.

In the event of a serious accident or illness, I request the school to contact me at the phone numbers listed. If the school is unable to reach me, I authorize the school to contact the physician or dentist indicated and follow his instructions. If it is impossible to contact the physician or dentist, the school may make whatever arrangements are necessary to provide emergency care and treatment for my child.

In the event of a life threatening accident or illness, I understand that the school may contact 911 emergency medical systems immediately. I agree to be financially responsible for the child's care and treatment.

INITIAL THOSE MEDICATIONS THAT YOU WISH TO GIVE PERMISSION FOR ICA STAFF TO ADMINISTER TO YOUR CHILD.

_____ Acetaminophen (non-aspirin)

_____ Antibiotic Ointment

_____ Caladryl Lotion (Calamine Lotion)

_____ No medication

_____ Other - Please Specify _____

Parent Signature: _____ Date: _____

Print Name: _____

Medication at School Letter

Dear Parent/Guardian(s):

In order to ensure student safety and health, Kerrington's Care Academy, Inc. has established a policy for the administration of medication during school hours. If your child must be given medication of any kind during school hours, including over the counter medications, you have the following choices: You, or an adult designated by you in writing, may come to the school and give the medication to your child. The clinic nurse/health contact may not be designated for this responsibility.

OR

You may get a copy of the Authorization for Medical/Treatment form from the school and take it to your child's physician, medical provider, the Health Department or a walk-in clinic. This form must be filled out and signed by the doctor/mid-level practitioner and the parent/legal guardian. Once completed, return this form to the school. Medication may be given at school, only when an Authorization for Medication/Treatment so that it will be available for their use.

OR

You may choose to discuss with your doctor/mid-level practitioner a schedule for giving medication outside school hours. School personnel are not allowed to give any medication to students unless they have received a properly completed Authorization for Medical/Treatment signed by you and your child's doctor/mid-level practitioner. A new authorization form is required at the beginning of each school year and anytime a medication or dosage is changed.

ONLY an adult may transport medications to and from the school clinic. Prescription medication must be received in the current pharmacy-labeled container. Over-the-counter medication must be received in the original container labeled with your child's name. Medication required to be split must be done either at home or by the pharmacist before it is brought to school. Clinic aides are not permitted to split medication.

For your convenience, a copy of the Authorization for Medication/Treatment is printed on the back of this letter. Take a copy of this form with you whenever you take your child to the doctor. This authorization form may also be picked up in the office of the school.

AUTHORIZATION FOR MEDICATION

KERRINGTON'S CARE ACADEMY, INC.

***The following section is to be completed and signed by the Parent/Guardian: Please Print Legibly: Child's Name**

Last	First	gender	grade	DOB
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Physician's Name	Address	Emergency Phone
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I hereby authorize the above-named physician and Kerrington's Care Academy, Inc. staff to reciprocally release verbal, written or faxed protected health information (PHI) regarding the above-named child for the purpose of giving necessary medication while at school. I understand (PHI) is confidential and is protected by the Health Insurance Portability and Accountability Act (HIPAA).

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as permitted by me and my physician (see below).

Date	Parent/Guardian Signature	Home/Cell phone	Emergency Phone
------	---------------------------	-----------------	-----------------

***The following section is to be completed by the PHYSICIAN:**

Please Print Legibly:

Diagnosis for which medication is given:

Name of medication:

Form: _____

Dose:

If medicine is to be given at school, at what time? _____

If medicine is to be given “when needed”, describe indications:

Please Print Legibly:

Diagnosis for which medication is given:

Name of medication:

Form:

Dose:

If medicine is to be given at school, at what time?

If medicine is to be given “when needed”, describe indications:

How soon can it be repeated?

List significant side effects?

Length of time this treatment is recommended:

Kerrington's Care Academy, Inc.

Medical Treatment Authorization Form

To Whom it may concern:

**I the undersigned parent/guardian of _____ hereby
authorize any necessary medical treatment for this student while participating in field trips
conducted under the sponsorship of _____ during the
_____ school year and guarantee payment of all
charges incurred as a result of this medical treatment.**

INFORMATION:

**ALLERGIES TO FOOD, MEDICATION, ETC. (If none, so
state).** _____

SPECIAL MEDICAL CONDITIONS (If none, so state).

**FAMILY
PHYSICIAN** _____

Office Address:

**Parent/Guardian
Name** _____

Parent/Guardian Address

Street
Address _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____
City

Insurance Company: _____ Policy No. or Group No. _____

Parent/Guardian Signature: _____ Date _____

STATE OF FLORIDA, COUNTY OF _____

I hereby certify that the foregoing was executed before me this
_____ day of _____, by
_____, who is personally known to me or who has
produced _____ as identification and
who did (did not) take an oath.

Notary Public, State of Florida

**THIS FORM IS TO BE USED FOR ALL OUT-OF-COUNTY FIELD TRIPS EXCEPT
ATHLETIC ACTIVITIES. THE FORM SHOULD BE COMPLETED PRIOR TO THE
STUDENT'S FIRST OUT-OF-COUNTY TRIP AND RETAINED ON FILE FOR THE
REMAINDER OF THE SCHOOL YEAR.**

Kerrington Care Academy Permission Forms

IN THE EVENT OF AN EMERGENCY WE WILL ACCESS THE 911 EMERGENCY SYSTEMS. IF YOU WOULD LIKE TO GIVE THEM PERMISSION IN ADVANCE TO BEGIN TRANSPORT AND TREATMENT OF YOUR CHILD, PLEASE SIGN THE FOLLOWING STATEMENTS.

PERMISSION TO TRANSPORT STATEMENT

I/We hereby state that I am the parent or guardian of the child named on this form. In order to expedite transportation to the preferred or appropriate medical facility, according to what they deem is indicated by the nature or extent of the injuries, I/We authorize the transportation of my/our child. I/We agree to be financially responsible for this child's treatment and transport. I/We will notify the school of any changes of this information in writing.

Student

Name: _____

Parent Name (Printed):

Parent

Signature: _____

PERMISSION TO TREAT STATEMENT

I/We do hereby state that I/We are the parent or guardian of the child named on this form. In order to expedite care of the child, I/We give permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I/We agree to be financially responsible for this child's treatment. I/We also request that the admitting facility notify one of the other persons listed on the emergency contact form of the child's condition and admission.

Student

Name: _____

Parent Name (Printed):

Parent
Signature: _____

STUDENT LIKENESS WAIVER AGREEMENT

I/We understand that my/our child's likeness may be videotaped by the school in the course of school activities. I/We hereby give consent for the school to use my/our child's likeness for promotional and/or advertising materials.

Parent Signature: _____
Date: _____ Notary Seal:

STATE OF FLORIDA, COUNTY OF _____, On this day of _____,
personally appeared before me _____, to me known to be the person(s)
described in and who executed the within and foregoing instrument, and acknowledged that
he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein
mentioned.

Witness my hand and official seal hereto affixed:

this _____ day of _____,
_____.

Notary Public in and for the State of _____ My commission expires
_____.

**Every student that rides the vans or any other KCA transportation MUST have this
copy signed by the parent.**

Kerrington Care Academy

Transportation & Medical Waiver Release Form

Parent Name _____
Student Name: _____

,

Kerrington Care Academy
EVENTS, EMPLOYEES,
AFFILIATES AND LOCATIONS.

Scheduled to begin on the date of entrance into KCA and will remain in effect until revoked in writing by the parent.

In consideration of participation in this school and any events, I agree, as the above named, his/her heirs and representatives to fully and forever release, discharge and covenant not to sue Kerrington Care Academy staff person, their officers, servants, agents, volunteers and employees (hereinafter referred to as RELEASES), from any and all liability, claims, demands, damages, actions, of causes of action, whatsoever arising out of or related to belonging to me, whether caused by negligence of the releases, or otherwise, while participating in such activity, or while in, on, or upon the premises where the activity is being conducted or in transportation to and from said premises. To my knowledge, the above names can fully participate in any activity. I am fully aware of risks and hazards connected with this type of educational facility, including but not limited to the risks as noted herein, and I hereby elects to voluntarily assume full responsibility for any risks of loss or damage to property owned by me, as a result of being engaged in such an activity and or program, whether caused by the negligence of releases or otherwise. It is my express intent that this release and hold harmless agreement shall bind the members of my family and spouse (if any), If I am alive, and my heirs, assigns, and personal representatives, if I am not alive, shall be deemed as a release, waiver, discharge and covenant not to sue the above named releases. I hereby further agree that this waiver of liability and hold harmless agreement shall be construed in accordance with the laws of the state of Florida. I understand that the school will not be responsible for any medical costs associated with an injury I may sustain. I further agree to become familiar with the rules and regulations of the school concerning, conduct and not to violate said rules of any directive or instruction made by the person or persons in charge of said activity and or Program and that I will further assume the complete risk of any activity done in violation of any rule or directive or instruction. I also understand that I should and am urged by Kerrington Care Academy to obtain adequate health and accident Insurance to cover any personal injury that may be sustained during the activity, Program or the transportation to and from said activities.

I HEREBY FURTHER AUTHORIZE IN ADVANCE ANY NECESSARY MEDICAL TREATMENT REQUIRED BY THE ABOVE NAMED WHILE IN ATTENDANCE OF THIS SCHOOL OR OUTSIDE ACTIVITY. I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL TO ORDER INJECTION AND/OR ANESTHESIA AND/OR SURGERY FOR MY CHILD AS NAMED ABOVE. I FURTHER AGREE TO ASSUME RESPONSIBILITY

FOR THE COSTS OF ANY SPECIALIZED EVACUATION AND OF ANY MEDICAL CARE AND ACKNOWLEDGE THAT THESE COSTS ARE THE FINANCIAL RESPONSIBILITY OF THE UNDERSIGNED. I ALSO ACKNOWLEDGE THAT I HAVE/WILL NOTIFY THE PROGRAM/EVENT PERSONNEL OF ANY SPECIAL MEDICAL NEEDS OR INFORMATION REQUIRED BY THE ABOVE NAMED.

I have reviewed the above information and am aware of the risks involved in participating in the Kerrington Care Academy TRANSPORTATION & ACTIVITIES and the possible injuries that may occur. I freely and voluntarily agree to participate in the activity listed herein. In signing this release, I acknowledge and represent that I have read the foregoing waiver of liability and hold harmless agreement, understand it and sign voluntarily as my own free act and deed; no oral representation, statements or inducements, apart from the foregoing written agreement, have been made; I am least eighteen (18) years of age and fully competent; and I execute this release for full, adequate, and complete consideration fully intending to be bound by same. Also, I understand that all rules and regulations for the Kerrington's Care Academy will be enforced and any violation by me can result in immediate dismissal from the School, Program and/or Events.

Emergency contact Name _____

Emergency Phone Number: _____

Signature of Parent _____ Date: _____

Witness Signature: _____

Date _____

Notary Seal:

STATE OF FLORIDA, COUNTY OF _____, On this day of _____, personally appeared before me _____, to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned.

Witness my hand and official seal hereto affixed:

this _____ day of _____,

_____.

Notary Public in and for the State of _____ My commission expires

_____.

Kerrington Care Academy
Transportation/Field Trips/Activity
Addendum Waiver

I understand that Kerrington Care Academy Assumes no responsibility for injuries or illnesses which students may sustain as a result of their physical condition or resulting from participation in any activities or transportation to any activity. I expressly acknowledge on behalf of myself and my heirs that I assume the risk for any and all injuries and illnesses, which may result from my child's participation in any activity. I hereby release and discharge Kerrington Care Academy, its agents, servants and employees from any and all claims for injury, illness, death, loss, or damage which I or my child may suffer as a result of any participation in these activities.

I acknowledge the waiver set forth above and by signing I am in agreement with it.

Parent/Legal Guardian Signature_____ Date_____

Printed Name_____

Student Name

Kerrington Care Academy
New Student Financial Form

Financial Administrator Department

Student Name: _____

Address: _____

Parent Name: _____

Contact Number: _____

Email: _____

Last School Attended: _____

Age: _____ Grade: _____

Do students have a Scholarship? Yes No

If yes, name of scholarship: _____

Fees due: _____

Student Planner: _____

Notarized documents enclosed:

Notes:

List any other pertinent information that the finance department should know about the student:

Monies Collected: _____

Amount Due:

Explain Payment Plan: _____

Parent Signature:

Date: _____

Parent Financial Agreement

Student Name: _____ Age: _____ Grade: _____

Parent Name: _____ Phone Number: _____

Does the student have a scholarship? ☐ Yes ☐ No Name of Scholarship: _____

Please provide a copy of the award letter with documentation.

If an item is checked off then it is covered under the scholarship. If there is no check mark next to the item the parent is responsible for payment. This form will serve as an agreement to pay:

Applicable	Items/Amounts	Scholarship Covered	Not
_____	Tuition <input type="checkbox"/> with <input type="checkbox"/> without tutoring	<input type="checkbox"/>	<input type="checkbox"/>
_____	Curriculum	<input type="checkbox"/>	<input type="checkbox"/>
_____	Transportation	<input type="checkbox"/>	<input type="checkbox"/>
_____	Registration	<input type="checkbox"/>	<input type="checkbox"/>
_____	Uniforms	<input type="checkbox"/>	<input type="checkbox"/>
_____	Tutoring	<input type="checkbox"/>	<input type="checkbox"/>
_____	Planner Package		
_____	Misc. – Including:		

	Total: _____		

- If payment is not received by Friday of each Biweek, a \$10.00 late fee will be applied.
- Outstanding balances will result in withholding of grades and transcripts.
- Unpaid amounts can cause interruption in student attendance.

Payment Arrangement:

☐ Bi-Weekly: _____ ☐ Monthly: _____

Start Date: _____ End Date: _____

I understand and agree with the above statements and amounts.

Parent Signature: _____ Date: _____

Administrator Signature: _____ Date: _____

Kerrington Care Academy
New Student Checklist – Parent Copy

Date: _____

Grade: _____

Childs

Name: _____

Parent's Name: _____

Documents

All forms listed below should be completed and submitted by parent upon registration of student

Students cannot start attending classes until ALL documents are received

_____ Complete Enrollment Package

_____ Withdrawal Form from Previous School

_____ Authorization for Release of Student Records Form

_____ Copy of Birth Certificate

_____ Copy of Social Security Card

_____ Copy of Shot Record

_____ Copy of Updated Physical

_____ Copy of Parent Identification

_____ Copy of Proof of Residence

Kerrington Care Academy

Grade: _____ Date: _____

Childs
Name: _____

Parent's Name: _____

Cumulative Folder Documents (office use only)

All forms listed below should be completed and submitted by parent upon registration of student

- ____ Withdrawal Form from Previous School
- ____ Authorization for Release of Student Records Form
- ____ Enrollment Application
- ____ Copy of Birth Certificate
- ____ Copy of Social Security Card
- ____ Copy of Shot Record
- ____ Copy of Updated Physical
- ____ Student Emergency Medical Form
- ____ Health Consent Form
- ____ Transportation Waiver
- ____ Copy of Parent Identification
- ____ Copy of Proof of Residence
- ____ Permission for Photos & Videos
- ____ Parent Financial Agreement – Completed by office staff only

AFTER PRINCIPAL APPROVAL

- ☐ Update Roster
- ☐ Update Master List
- ☐ Update Email List
- ☐ Enter Engrade
- ☐ Teacher Notification
- ☐ Financial Office Notification
- ☐ Update Transportation
- ☐ Staff Notification Email

Initials

Date

Admin Staff Completing Form: _____

Date: _____

Principal Review and Approval: _____
Date: _____

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Kerrington Care Academy

920 County Road 46 Leesburg Fl 34748

Principal/Director

Latisha Ward-Williams

Phone: 352-787-7100

Name of Student: _____
First Middle Last

Date of Birth: ____ / ____ / ____ Grade: ____ Date: ____

The above name student has enrolled in our school. Please forward these records as soon as possible.

1. Former and Current Grades
2. Cumulative School Record
3. Standardized Test Results
4. Health Records
5. Individual Education Plan
6. Psychological/Confidential Records
7. Consent of Evaluation/Placement
8. Official Transcript with Seal
9. Other _____

I do hereby authorize _____

Street Address City/State Zip
Phone _____

To release all records and information regarding the student named above.

**PLEASE FAX ALL RECORDS REQUESTED ABOVE TO:
Attention: REGISTRAR FAX: 352-787-7110**

Parental permission is no longer required when records are requested by authorized school personnel. (Family Education Rights and Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976 Vol.41 No.118, P.24673)

Kerrington Care Academy 2024-2025 Fee Schedule

Tuition and Financial Aid

New Student Enrollment Fee	Returning Student Enrollment Fee
\$300	\$250

<u>Grade Level</u>	<u>Annual Tuition</u>	<u>*Fees</u>	<u>Monthly Break down</u>	<u>Total</u>
PreSchool	\$11,280	\$990	\$1,128	\$12,270
Kindergarten	\$12,445	\$1,250	\$1,227	\$13,695
Grades 1-5	\$15,870	\$1,250	\$1,587	\$17,125
Grades 6-12	\$18,530	\$1,395	\$1,853	\$19,925

*Preschool, Kindergarten, and grades 1-5 fees cover instructional materials, technology, activities, and 1 spirit shirt and 2 uniform shirts (additional shirts are \$20) .

* Middle and Upper School fees cover the yearbook, instructional materials, technology, activities, and 1 spirit shirt and 2 uniform shirts (additional shirts are \$20), and additional educational supplies.

* Field trips are not included in the tuition.



New Student Enrollment Notification

TO: ASSIGNED TEACHER

Student Name: _____ Grade: _____

Homeroom: _____ Start Date: _____

Parent Name: _____

Preferred Contact Phone Number: _____

Parent Email: _____

How does this student get home?

Does the Student have Siblings in school? YES NO

Sibling's Names &

Class: _____

Comments from Parent:

FOR OFFICE USE ONLY

Scholarship:_____ Date Enrolled:_____

Person that enrolled this student: