

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

Birthdate: _____ Gender: _____

Home Phone: _____ Home Address _____

City, _____ State: _____ Zip: _____

Parent Name: _____ Cell Phone: _____

Parent Email: _____

	Class	Day	Times	Tuition
	First Grade	M-F	8:30 am-1:00 pm	\$ 390.00 Per month
	Second Grade	M-F	8:30 am-1:00 pm	\$ 390.00 Per month
	Third Grade	M-F	8:30 am-1:00 pm	\$ 390.00 Per month
	Fourth Grade	M-F	8:30 am-1:00 pm	\$ 390.00 Per month
	Fifth Grade	M-F	8:30 am-1:00 pm	\$ 390.00 Per month
	Sixth Grade	M-F	8:30 am-1:00 pm	\$ 390.00 Per month
**	We offer all of the classes in a Hybrid form also.			

Tuition is established on a yearly fee which is based on the number of days the class runs from September to June. Fees are not pro-rated for vacations or illness. The registration fee is due at the time of registration. Tuition is paid in equal monthly installments. September-June. Students entering the program after the start date will be required to pay the full registration fee as stated. A **\$25 late fee** will be issued **monthly** to any account with a balance past due.

All fees are non-refundable. Non-refundable Registration Fee: \$175.00

I understand I am responsible for all tuition and fees for each month that my child attends school for the 2025/2026 school year.

Signature Acknowledgement: _____ **Date:** _____

Monthly Tuition pays for the spot in the class, not the amount of days your child attends class.

Does your child have any allergies to food, medication, pets, other? (Please describe):

If yes does your child require medication for this allergy (i.e. Epi-Pin)? _____

Does your child have any food or dietary restrictions (i.e. vegetarian, gluten free, vegan, etc)? (Please describe):

Does your child have any special needs? (If yes, please explain): _____

If yes, are you currently working with ESD / Early Intervention? _____

In the event The Virginia Kathryn School determines serious enough for medical attention and a parent cannot be reached, I authorize LPS to arrange medical transportation and obtain medical services for my child. (initial here to authorize) _____

In addition to the parents listed on the front, please list the following individuals who are authorized to pick up or remove your child from school.

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____

Emergency Phone Contact Outside the Portland Metro Area: _____

Phone: _____ Relationship to child: _____

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