Camas Premier Academic Christian Preschool

Location: 2436 NW Astor St, Camas, WA 98607

Phone: (360) 771-5047

Email: sarahhigley.camaspac@gmail.com

Website: camaspacpreschool.org

Mailing Address: P.O. Box 314
Washougal, WA 98671

Student Information (Please Print)

GENERAL INFORMATION

Last:_____ First:_____ Middle:_____

Child's Nickname, if any:_____

Birth Date:_____ Age as of September 1, 2025:_____

Gender: Female Male. Ethnicity:_____

Language spoken at home:_____

HEALTH & SOCIAL INFORMATION

Food Allergies:_____

Your Child's eating habits are: Good Average Poor

Does your child feed himself/herself entirely? Yes No

Can your child decide when he/she needs to go to the bathroom?_____

Is your child currently having trouble being separated from you?_____

Are there any special circumstances in the family which may be a factor in your child's present behavior (New baby, recent move, divorce, death, hospitalization, etc.) ?

_____

_____

Does your child have academic/social/emotional difficulties that we should be aware of?

_____

_____

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Has your child been diagnosed by a licensed healthcare provider with any chronic illnesses?_____

_____

Is any medication needed at home?_____

_____ _____

Name of Physician/Licensed Healthcare Provider Phone

Date of last well-child exam:_____

Family Information

PARENT INFORMATION

Parent/Guardian:_____ Relationship:_____ Home Phone:_____

Email:_____ Work Phone:_____

Parent/Guardian:_____ Relationship:_____ Home Phone:_____

Email:_____ Work Phone:_____

Home Address:_____

City:_____ State:_____ Zip:_____

SIBLING INFORMATION

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

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SECONDARY HOUSEHOLD (if applicable)

Parent/Guardian:_____ Relationship:_____ Home Phone:_____

Email:_____ Work Phone:_____

Parent/Guardian:_____ Relationship:_____ Home Phone:_____

Email:_____ Work Phone:_____

EMERGENCY CONTACT

In the event that we cannot reach a parent/guardian, please list below approved people to be contacted if your child is ill, injured, or needs immediate attention. Only the people on this form are authorized to remove your child from the school unless prior notice is given.

1) Name:_____Relationship:_____

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

2) Name:_____Relationship:_____

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

3) Name:_____Relationship:_____

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

PHOTO AND WEB PAGE RELEASE

My child may be included in photos for school publications, advertisements, website, videos and slide production. Their name will not be included in conjunction with any photos.

Photos may be seen on Facebook to share with families and advertise CPACP to the public.

_____Yes. _____No

_____ _____

Signature: Date:

CPACP Medical Treatment Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form will be filed and kept with the child's registration information.

Minor

Full Legal Name:_____

Home Address:_____

Date of Birth:_____ Gender: Female:_____ Male:_____

Information for Medical Treatment

Physician's Name:_____

Location:_____Physician's Phone:_____

Medical Insurer/Health Plan:_____

Allergies to Medication:_____

Allergies (Other):_____

Please note all conditions for which the child is currently receiving treatment:_____

_____

Note any other significant medical information:_____

_____

Authorization and Consent of Parent(s) or Legal Guardian(s)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____**CPACP**_____ (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment or hospital deemed care advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgement upon the advice of any such medical or emergency personnel.

This authorization is effective through: June 30th, 2026

Parent/Legal Guardian Signature:_____ Printed Name: _____

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Student Name:_____

Parents/Guardian Name:_____

Registration Fee: $200	This must be paid to hold your students spot and cannot be added to tuition or other fees. Non refundable.	Total:_____ Paid:_____

TUITION CALCULATION

Tuition Family Total:	$

PAYMENT ARRANGEMENTS

10 Monthly Payments (August 2025-May 2026)	$

We understand that tuition is due on the first of each month or on the 1st day of your child's class each month. In the event of insufficient funds, a $25 fee will be added to your account.

_____ _____
Parent/Guardian Date

By signing below, I acknowledge that I have read, understand, and agree to follow the policies and procedures as they are written in the CPACP Family Policy and Procedures Handbook.

_____ _____
Parent/Guardian Date