Location: 1410 S. Hillhurst Ridgefield, WA 98684

Phone: (360) 605-9397

Email: sarahhigley.rpacp@gmail.com



Website: www.ridgefieldacp.weebly.com

Mailing Address: P.O. Box 314

Washougal, WA 98671

Student information (i lease i	inity	
GENERAL INFORMATION		
Last:	First:	Middle:
Child's Nickname, if any:		
Diate Date:	Assault Cond	hamala au 1 0000.
Birth Date:	Age as or Sept	tember 1, 2023:
Gender: Female Male.	Ethnicity:	
Language spoken at home:		
3 3 1 =		
HEALTH & SOCIAL INFORMA		
Food Allergies:		
Your Child's eating habits are	: Good Average P	Poor
Does your child feed himself/	herself entirely? Yes	No
Can your child decide when h	ne/she needs to go to the hat	hroom?
Carryour crima decide when i	ic/sile ficeds to go to the batt	
Is your child currently having	trouble being separated from	you?
Are there any special circums recent move, divorce, death,		ay be a factor in your child's present behavior (New baby,
Does your child have academ	nic/social/emotional difficulties	s that we should be aware of?

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Has your child been diagnosed b	by a licensed healthcare pr	ovider with any ch	ronic illnesses?	
Is any medication needed at hon	ne?			
Name of Physician/Licensed Hea	althcare 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:			

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SECONDARY HOUSE	HOLD (if applicable)			
Parent/Guardian:	Relationship:_	Home Phone:		
Email:		Work Phone:		
Parent/Guardian:	Relationship:_	Home Phone:		
Email:		Work Phone:		
EMERGENCY CONTA				
	nmediate attention. Only the people of	e list below approved people to be contacted if your child is on this form are authorized to remove your child from the		
1) Name:		Relationship:		
Home Phone:	Cell Pho	one: Work Phone:		
2) Name:		Relationship:		
Home Phone:	Cell Pho	one: Work Phone:		
3) Name:		Relationship:		
Home Phone:	Cell Pho	one: Work Phone:		
PHOTO AND WEB PA	GE RELEASE			
	ded in photos for school publications included in conjunction with any pho	s, advertisements, website, videos and slide production. otos.		
Photos may be seen o	on Facebook to share with families ar	nd advertise RPACP to the public.		
Yes.	No			

Date:

RPACP 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.

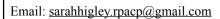
Minor

Full Legal Name:		
Home Address:		
Date of Birth:		
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 cl	hild is currently receiving treat	ment:
Note any other significant medical information		
Authorization and On I do hereby state that I have legal custody consent for RPACP aid treatment for any minor injuries or illness threatening or in need of emergency treat professional emergency personnel to attex X-ray, anesthetic, blood transfusion, medical deemed care advisable by, and to be rend surgeon, dentist, hospital, or other medical in which such treatment is to occur. I agree care.	(hereafter "Designated esses experienced by the Mindement, I authorize the Designatend, transport, and treat the mication, or other medical diagratered under the general superal professional or institution du	I grant my authorization and Adult") to administer general first or. If the injury or illness is life sed Adult to summon any and all inor and to issue consent for any nosis, treatment or hospital vision of, any licensed physician, aly licensed to practice in the state
It is understood that this authorization is g provide authority and power on the part of judgement upon the advice of any such m	of the Designated Adult in the	exercise of his or her best
This authorization is effective through: Jun	ne 30th, 2024	
Parent/Legal Guardian Signature:	Printe	d Name:

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Phone: (360) 605-9397

Parent/Guardian





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

	Student Name:					
Parents/Guardian Name:						
	Registration Fee:	This must be paid to hold your students spot and cannot be added to tuition or other fees. Non refundable.			Total:	
TUITION CALCULATION						
Tuition	Family Total:			\$		
PAYMENT ARRANGEMENTS						
9 Mon	thly Payments (Sept 2023-	May 2024)		\$		
We understand that tuition is due on or before the 5th of each month. In the event of insufficient funds, a \$25 fee will be added to your account.						
Pare	ent/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 RPACP Family Policy and Procedures Handbook.						

Date