# NEW TESTAMENT CHRISTIAN ACADEMY (NTCA)

2021-2022 Admissions Checklist

Dear Prospective NTCA Family and **current** NTCA families with **NEW** students applying for enrollment.

Thank you for applying to NTCA. Our goal is to help all of our students reach their highest potential in Christ and academically. We aim to partner with parents to achieve these goals. You have started the process of enrollment at our school. **This process has two parts:**

## Part A - Securing a voucher to pay for tuition - Choice Application:

If you are applying for the Parental Choice Program, we must receive your Choice application along with all items listed below:

____ A printout of the ONLINE 2021-2022 MPCP/WPCP Choice Application confirmation page.
http://dpi.wi.gov/sms/choice-programs/student-applications
____ Income verification (Provide a signed copy of your 2020 Income Taxes)
____ Proof of residency for MPCP or WPCP (Example: **Most recent** utility bill or lease agreement)
____ Signed Tuition Payment Authorization Form (Included below)
____ Supporting documentation required by DPI

**By state statute**, we are not permitted to accept the Choice documents after the open enrollment period, which is the 20th of the month for the MPCP and April 15th for WPCP.

## Part B - Securing a seat at NTCA for new students - NTCA Application:

____ Completed 2021-2022 Online Admission Application Form (www.ntcacademy.org)
____ Immunization / Permission to access WIR (Included below)
____ Health History Record and Emergency Care Plan (Included below)
____ Authorization to administer Medication and Child Care Centers (Included below)
____ Student's official birth certificate
____ 1st - 8th grade only:
  _____ Copy of most recent report card
  _____ Copy of most recent Standardized Test Scores
  _____ Copy of IEP / Educational Plans
  _____ Formal Teacher Recommendation Form completed by a teacher at the current school (Included below)
____ Private-pay families ONLY: TextBook fees due before August 1
____ Private-pay families ONLY : Non-refundable **$50.00** Application Fee due with this application
_____ Admissions Checklist (Completed) – **Return this checklist with your materials**

## APPLICATIONS CANNOT BE ACCEPTED WITHOUT ALL OF THE AFOREMENTIONED ITEMS

***Note to all:***

- If applying for K4 or K5, your child must have reached that age **on** or **before September 1st.**
- The school **does not** provide transportation for students.

After the information has been received, your admissions application will be processed. Please forward all of the above items to the academy office as soon as possible. If you are unable to print the requested documents, please contact our school for pre-printed forms. If you have any questions, please feel free to contact the academy office at **414-365-1677**. Thank you!

**"Train up a child in the way he should go so that when he is old, he will not depart from it." Proverbs 22:6**

NTCA

**New Testament Christian Academy**

**MILWAUKEE PARENTAL CHOICE PROGRAM /**
**WISCONSIN PARENTAL CHOICE PROGARM**
**TUITION PAYMENT AUTHORIZATION**

The undersigned, parent of a student enrolled at **NEW TESTAMENT CHRISTIAN ACADEMY**, authorizes the school to:

1) Receive from the Wisconsin Department of Public Instruction periodic checks made out to the parent in consideration of a scholarship granted to the child of the parent to attend the school under the Milwaukee Parental Choice Program / Wisconsin Parent Choice Program, and

2) Endorse periodic checks on behalf of the parent payable only to the school as payment toward tuition being charged by the school for the education of the child of the parent under the provision of Wis. Stats. 119.23 and regulations promulgated thereunder.

The school is authorized to inform the Wisconsin Department of Public Instruction or the Milwaukee Public School District of the existence of this Authorization, and such entities are entitled to rely upon this Authorization, until receiving written notification that it has been rescinded.

**PARENT PORTION**

_____ _____

Parent/Guardian SIGNATURE Date

_____ _____

Parent/Guardian **PRINT** Name Student's Name **PRINT**

**SCHOOL PORTION**
ACCEPTED BY:

_____ _____

**SIGNATURE** Date

Renee Johnson, Academy Director

On behalf of: **NEW TESTAMENT CHRISTIAN ACADEMY**

**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-04020L (Rev. 6/2018)

**STATE OF WISCONSIN**
Wis. Stat. §§ 252.04 and 120.12 (16)

# STUDENT IMMUNIZATION RECORD

**INSTRUCTIONS TO PARENT:** COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

**PERSONAL DATA** **PLEASE PRINT**

**Step 1**

| Student's Name | Birthdate (MM/DD/YYYY) | Gender | School | Grade | School Year |
|---|---|---|---|---|---|
| | | | | | |

| Name of Parent/Guardian/Legal Custodian | Address (Street, City, State, Zip) | Telephone Number |
|---|---|---|
| | | |

**IMMUNIZATION HISTORY**

**Step 2**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

| TYPE OF VACCINE* | FIRST DOSE MM/DD/YYYY | SECOND DOSE MM/DD/YYYY | THIRD DOSE MM/DD/YYYY | FOURTH DOSE MM/DD/YYYY | FIFTH DOSE MM/DD/YYYY |
|---|---|---|---|---|---|
| DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis) | | | | | |
| Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td | | | | | |
| Polio | | | | | |
| Hepatitis B | | | | | |
| MMR (Measles, Mumps, Rubella) | | | | | |
| Varicella (Chickenpox) Vaccine *Vaccine is required only if your child has not had chickenpox disease. See below:* | | | | | |

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
☐ YES _____ Year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If YES, provide laboratory report(s)

**REQUIREMENTS**

**Step 3**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

**COMPLIANCE DATA**

**Step 4**

**STUDENT MEETS ALL REQUIREMENTS**
Sign at Step 5 and return this form to school.

**Or**

**STUDENT DOES NOT MEET ALL REQUIREMENTS**

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

**NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.**

**WAIVERS** (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations _____

_____ _____
**SIGNATURE** - Physician Date Signed

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

**SIGNATURE**

**Step 5**

This form is complete and accurate to the best of my knowledge. Check one: ( I do ☐ I do not ☐ ) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

_____ _____
**SIGNATURE** - Parent/Guardian/Legal Custodian or Adult Student Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov

# HEALTH HISTORY AND EMERGENCY CARE PLAN

**Use of form:** This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

**CHILD INFORMATION**

| Name (Last, First, MI) | Birthdate (mm/dd/yyyy) | First Day of Attendance (mm/dd/yyyy) |
|---|---|---|
| | | |

| Home Address (Street, City, State, Zip Code) |
|---|
| |

**PARENT / GUARDIAN INFORMATION** Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

| Name | Primary Telephone Number | Work Telephone Number | Secondary Telephone Number |
|---|---|---|---|
| | | | |
| Name | Primary Telephone Number | Work Telephone Number | Secondary Telephone Number |
| | | | |

**PHYSICIAN / MEDICAL FACILITY INFORMATION**

| Physician Name | Medical Facility Address | Telephone Number |
|---|---|---|
| | | |

**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

| | Brand Name | Ingredient Strength |
|---|---|---|
| ☐ Yes ☐ No I authorize the center to apply sunscreen to my child. | | |
| ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen. | | |
| ☐ Yes ☐ No I authorize the center to apply repellent to my child. | | |
| ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent. | | |

**HEALTH HISTORY AND EMERGENCY CARE PLAN** If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma
☐ Diabetes
☐ Gastrointestinal or feeding concerns, including special diet and supplements
☐ Cerebral palsy / motor disorder
☐ Epilepsy / seizure disorder
☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

| **SIGNATURE** – Parent or Guardian | Date Signed (mm/dd/yyyy) |
|---|---|

**Review dates:** _____ _____ _____ _____ _____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education



# AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
# MEDICATION INFORMATION AND AUTHORIZATION

## A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

| Name – Child | Birthdate (mm/dd/yyyy) |
|---|---|
| | |

## B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

| Name – Medication | Dosage | Time(s) of Day to be Administered | How to be Administered | Dates – Medication Time Period | |
|---|---|---|---|---|---|
| | | | | From | To |
| | | ☐ AM ☐ PM | | | |
| | | ☐ AM ☐ PM | | | |
| | | ☐ AM ☐ PM | | | |
| | | ☐ AM ☐ PM | | | |

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes," I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

Name – OTC Medication _____ Parent Initials _____

Additional information / special instructions / contraindications – Specify.

## C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

| **SIGNATURE** – Parent or Guardian | Date Signed |
|---|---|
| | |

## AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
## DOCUMENTATION OF MEDICATION ADMINISTRATION – CERTIFIED CHILD CARE PROVIDERS

**Instructions:** This section is to be completed only by **certified child care providers** to document the actual administration of the medication. Lines should not be skipped.

| | Date Administered | Time Administered | Dosage | Signature / Initials of Person Who Administered the Medication |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
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# FORMAL TEACHER RECOMMENDATION FORM

*******Please have this form filled out by a former or current School Teacher*******

**STUDENT NAME: _____**

**PARENT NAME: _____**

**The above named student is applying for admission to New Testament Christian Academy. Please fill out the below information in reference to the above named child.**

How long have you known the student? _____

In what capacity do you know the student?

1. Please share any information about this child in regards to their special gifts or strengths.

2. Please share any areas that this child needs growth in or improvement.

3. What activities or clubs has this child been involved with in your school?

4. Tell why you think this child will do well at an advanced level school. Also, share what struggles they may face at an advanced level school.

5. Please share how the parent(s) has been involved in this child's progress.

_____ _____ _____

**Name of Person Filling Out this Form** **Title** **Date**
**(Current or Former Teacher)**