OFFICE USE ONLY
Date paid: _____
Registration Fee Paid: _____
CK#: ____Cash: ___ CC: ____
Processed By: _____

Admission Application

Student Legal Name: _____ Nickname: _____
(Last) (First) (MI)

Date of Birth: _____ Social Security: _____ Age: _____ Gender: _____

Home Address: _____City/State/Zip: _____

Home Phone: _____ Secondary Phone: _____

Race: □ Black/African American □ White/Hispanic □ Asian □ American/Indian/Alaskan □ Pacific Islander

□ Other: _____

School Previously Attended: _____ Grade: _____

Mother's Information

Mother's Name: _____ Email: _____
(Last) (First) (MI)

Mother's Social Security #: _____

Home Address: _____ City/State/Zip: _____

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

Occupation: _____ Employer: _____ Address: _____

Father's Information

Father's Name: _____ Email: _____
(Last) (First) (MI)

Father's Social Security #: _____

Home Address: _____ City/State/Zip: _____

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

Occupation: _____ Employer: _____ Address: _____

Parent Status: □ Married □ Separated □ Divorced □ Widowed
In case of divorce, who has legal custody of child? _____

***Person's permitted to pick up child*:** Mother: □ YES □ NO Father: □ YES □ NO

List person(s) authorized to pick up child at school in place of parent:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contacts

List Person(s) other than parent, who can assume responsibility for child if parent cannot be reached immediately in case of an emergency (may be the same as above.)

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

Villa Lyan Inc school admits students of any race, color, national origin, and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. Villa Lyan Inc. does not discriminate on the basis of race, color, national origin, and ethnic origin in administration of it's educational policies, admission policies, scholarship and loan programs, and athletic and other school administered programs.

Medical Information

Diagnosis: _____ Medications: _____

Does student have: Seizures: ☐ YES ☐ NO Asthma: ☐ YES ☐ NO Eyeglasses/Hearing Aid: ☐ YES ☐ NO

Seizures: ☐ YES ☐ NO If "yes", please explain: _____

Dietary Restrictions: ☐ YES ☐ NO If "yes", please list: _____

Check off all communicable diseases your child has had (*please include approximate dates):*

☐ Rubella: _____ ☐ Mumps: _____ ☐ Measles: _____ ☐ Scarlet Fever: _____

☐ Chicken Pox: _____ ☐ Meningitis: _____ ☐ Other: _____

Name of Student's Health Insurance: _____ Policy #: _____

Name of Student's Doctor: _____ Office Phone: _____

Does your child currently receive private therapy? If "yes", please check off therapy discipline and indicate frequency.

☐ Speech-Language Therapy: _____ ☐ Physical Therapy: _____ ☐ Occupational Therapy: _____

Attachments:

Please attach the following items as they pertain to your child:

1. Copy of the most recent IEP completed for your child
2. Documentation of diagnosis from medical professional in the form of a prescription or letter.
3. Psychiatric or Psychological Evaluation, conducted privately or by Public School System
4. Recent Speech-Language, Occupational, Physical Therapy evaluations, conducted privately or by Public School System.
5. Copy of student's birth certificate.
6. Immunization Card
7. Copy of Parent's ID.

AGREEMENT/DISCLAIMER

I/we have read all the above and have filled out the questions truthfully and to the best of our ability. I have read and agree to abide by Villa Lyan's **"RULES AND REGULATIONS HANDBOOK"** and the School's **Disciplinary Practices and Procedures**, per Section 65C-22.006(4)(c)2, F.A.C. I understand that the Administration may amend these as needed. I hereby give permission for my child's picture(s) to appear in the school website, public videos/films and/or the school yearbook and/or other school-related publication. I understand that both my child and I will be required to sign the "AGREEMENT REGARDING COMPUTER/INTERNET USAGE" in order for child to utilize the school computers to access the Internet. I hereby authorize Villa Lyan to obtain all pertinent records from the school my child previously attended, if applicable.

I understand that **TUITION** is due monthly, **IN ADVANCE**, on the **FIRST DAY** of each month, based on a 10-month school year, from August to May. I hereby understand that there will be **NO REFUNDS** and **NO DISCOUNTS** made for days or weeks absent from school. I understand there is a late payment penalty of $25.00 if tuition is not paid before the 10th day of each Month. I further understand that if tuition is not paid by the 15th day of the month, my child will not be accepted in class and his/her enrollment may be terminated automatically. A penalty of $50.00 must also be paid for all checks returned by the bank. I hereby Authorize Villa Lyan to give First-Aid treatment to my child in case of an emergency. I understand that Insurance will cover Emergency treatment ONLY, not hospitalization

DISCLAIMER: I understand that Villa Lyan, its Owner/Director, employees or volunteers will NOT be liable for any accidents or incidents that may occur in or around the school property or during any extra-curricular activity. I understand that in order for my child to be registered, the school must have the following.

☐ Report Cards/SAT's from Previous School ☐ Villa Lyan's signed "Agreement Form"

☐ Immunization Records(Form DH 680 or 681blue) (per Section 65C-22.006(2), F.A.C.) ☐ Current Physical Examination (Form DH 3040/Yellow)(per Section 65C-22.006(2), F.A.C)

_____ _____

Signature of Mother/Legal Guardian Date

_____ _____

Signature of Father/Legal Guardian Date

Annual Fee Schedule

Program	✔	Annual Tuition	Annual Registration Fee
K-5, Base		$22,500.00	$250.00
6-12, Base		$22,500/00	$250.00
SPECIAL PROGRAMS		**Additional Tuition**	
K-12 Fit Education		$7,500.00	$250.00
K-12 Access Community		$10,000.00	$250.00
K-12 Access Communication		$22,500.00	$250.00
TOTAL		**+**	**$250.00**

$

- Registration fee includes: Academic testing for current levels and adaptive measures.
- Admissions Assessment Test is $100.00
- There is a $200.00 per year discount for each additional child in the family: (Brother/Sister relationship only)
- Any other recommended individualized treatments, including Speech-Language therapy, Occupational Therapy, Physical Therapy and/or Psychological Counseling, will be charged separately.
- Transportation to/from Campus is not included and must be paid directly to sub-contracted company.

CHECK OFF PAYMENT SCHEDULE: **_____**Monthly _____Quarterly _____Annually

Has student been approved to receive funding from the McKay Scholarship? ___ YES ___NO
If "YES", what is the Matrix Number: _____
Indicate Primary Diagnosed Exceptionality: _____

Financial Agreement

The amount of $_____ is hereby paid for the **20__/20__ REGISTRATION FEE**. I understand that this fee is **NON-REFUNDABLE**. I agree to be responsible for the costs of all initial Evaluations and all follow-up treatments or therapeutic interventions, if necessary. I understand I will be responsible for all late payment penalties and Attorney's Fees if this account is sent to collection. I understand that my child will be required to follow all the RULES & REGULATIONS of Villa Lyan as stated in the published "HANDBOOK" in order for him/her to maintain their enrollment at the schoo. **Violation of the school's rules may result in immediate expulsion.**

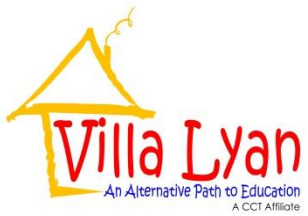
I also understand that I will be expected to cooperate with the school's numerous fund raising events.

McKAY RECIPIENTS: I/we hereby assume full responsibility for the annual tuition of $_____ which represents the difference in tuition not covered by the funds approved for my child from the McKay Scholarship.

I have already filled out the "REGISTRATION FORM" giving the school all the pertinent information regarding my child. I hereby authorize Villa Lyan, its employees or volunteers to give First-Aid treatment to my child in case of an emergency. I understand that I will be responsible for payment of all initial and/or ongoing evaluations. I hereby authorize my child to be transported by a sub-contracted bus/van to and from the campus and all Field Trips scheduled by my child's teacher. I further relieve Villa Lyan, it's Owners, Directors, Employees, and volunteers of any and all liability as to any type of accident or incident that my child may be involved in during these trips, or before, during and after school hours. I have been shown the entire school campus, including all Play areas, and have found them to be safe and suitable for my child. I hereby give permission for my child's photo(s) to be published in the school Yearbook, the school's website, digital monitor, school brochure, or other school publication.

_____ _____
Signature of Mother/Legal Guardian Date

_____ _____
Signature of Father/Legal Guardian Date



Release and Waiver of Liability

I, the parent of _____, understand and assume the risk of all and any injury that may occur to my child prior to, during and/or after any camp activity including but not limited to equine, sports, fitness, pool and water play activities, transportation to and from camp location and/or field trips.

I understand and acknowledge that any involvement with horses can be extremely dangerous. I voluntarily and expressly assume all liability and risks knowing fully the possibility of injury, regardless of the cause of such injury.

In consideration of having been forewarned of the possibilities of injuries that may occur as a result of any activities, either precedent to, during or after any camp activities as described above we do agree by this instrument not to sue Creative Children Therapy, Villa Lyan, its agencies, agents or employees. I or my heirs waive and release any and all claims arising out of such camp activities or the use of such property, including, but not limited to claims alleging negligence, strict liability, breach of contract, loss of severance. This agreement to not sue includes claims for bodily injury, property damage, death or any other claim which I and my heirs may have against Creative Children Therapy and/or Villa Lyan.

Child's Name _____

Parent's Name _____

Parent's Signature _____ Date _____

Authorization for Photography and Video Release

I, _____ the parent and/or guardian of _____ hereby authorize and give consent to service providers and the staff of Villa Lyan as follows:

I hereby consent and authorize the staff of Villa Lyan to take/use still photographs, digital photographs, motion pictures, television transmission and/or videotaped recordings (hereinafter "Recordings) of me, my children, or my wards for educational, research, documentary, and public relations purposes. Any such Recordings may reveal my identity through the image itself without any compensation to me, my children, or my wards.

Any and all Recordings taken of me shall be the sole property of Villa Lyan. Under approved tapings and publications, outside sources including but not limited to television news stations and The Miami Herald will have property of the said Recordings. With regard to the use of any Recordings taken of me, my children, or my wards, I hereby waive any and all present and future claims I may have against Villa Lyan, their staff, service providers, employees, agents, affiliates, and Board Members.

_____ _____

Signature of Parent or Guardian Signature of Witness

_____ _____

Date Date

Authorization for Medication

I, _____, the parent and/or guardian of _____,

(Parent/Legal Guardian Name) *(Student Name)*

authorize the staff of Villa Lyan and/or Creative Children Therapy to administer the following designated medication to my child .

Name of Medication: _____

Describe the circumstances under which the medication is to be administered:

_____

_____

_____

Dosage: _____ Time: _____

In detail, describe how to administer the medication:

_____

_____

_____

_____

Parent/Legal Guardian Name

_____ _____

Parent/Legal Guardian Signature Date

Consent for Treatment

I, _____, the parent and/or legal guardian of
(*Parent/Legal Guardian Name)*
_____, give my consent to Villa Lyan
(Student Name)
and/or Creative Children Therapy to administer therapeutic treatment to include Speech-Language therapy, Occupational therapy, physical therapy, and/or massage therapy. This treatment is considered necessary in the best judgment of the treating clinician. This consent is given in prior to any such treatment, but is given to provide authority and power on the part of the staff to exercise their best judgment upon the advice of any clinical personnel.

Furthermore, in case of an injury or illness that is life threatening or in need of emergency treatment, I authorize the Villa Lyan and/or Creative Children Therapy staff to summon any and all professional emergency personnel to attend, transport, and treat the student and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnostic, treatment or hospital care deemed 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 participate in the state in which such treatment is to occur.

I authorize the Villa Lyan and/or Creative Children Therapy staff to administer topical Benadryl ointment/cream to my child in case of redness, swelling, itching, and/or mild rash as a result of external allergens (e.g. cats, horses, dust, bug bites, detergent, soap, and any other allergens). I will provide Villa Lyan and/or Creative Children Therapy with a detailed list of any and all allergies of the student.

Student Name: _____

Mother's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Signature of Mother/Legal Guardian: _____ Date: _____

Father's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Signature of Father/Legal Guardian: _____ Date: _____

Contract Between Family & School

Parent/Guardian Involvement

Parent(s) and/or legal guardian of student(s) attending Villa Lyan are expected to participate throughout the school year in:

- ❖ Fundraisers
- ❖ School-related activities (Out-of-School activities, After-hour activities, etc.)
- ❖ PTO (Parent-Teacher Organization)

Parent(s) and/or legal guardian will be contacted throughout the school year by school staff and PTO coordinator regarding all school related activities and their assigned involvement.

1:1 Individual Therapy

Villa Lyan students receiving 1:1 Therapy Services (individual occupational, physical, and/or speech language therapy) during the school day will be billed to the child's insurance. The 1.1 Individual Therapy Services are NOT part of the school tuition.

□ I have read and understood the *Contract between Family and School*.

Student's Name: _____

Mother's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Signature of Mother/Legal Guardian: _____Date_____

Father's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Signature of Father/Legal Guardian: _____Date_____

Allergy Action Plan

Child's Name: _____ DOB: _____

Teacher: _____

Allergy to: _____

Asthmatic: ☐ YES* ☐ NO *High risk for severe Reaction

☑ Check signs of allergic reaction pertinent to your child.

- ☐ MOUTH - Itching, swelling of the lips, tongue, or mouth.
- ☐ THROAT - Itching and/or sense of tightness in the throat, hoarseness and hacking cough.
- ☐ SKIN - Hives, itchy rash and/or swelling about the face or extremities
- ☐ GUT - Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ LUNG - Shortness of breath, repetitive coughing and/or wheezing
- ☐ HEART - "thready" pulse, "passing out"

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation. ☐ **Yes** ☐ **No**

ACTION FOR MINOR REACTION:

1. If symptoms are: _____, give my child _____

(medication/dose/route)

Then call:

2. Mother_____, Father_____, or emergency contact
3. Dr. _____ at _____

If condition does not improve within ten minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION:

1. If ingestion/contact is suspected and/or symptom(s) are: _____, give my child _____ IMMEDIATELY.

(medication/dose/route)

Then call 911.

2. Rescue Squad (ask for advanced life support)
3. Mother_____, Father_____, or emergency contact
4. Dr. _____ at _____

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Asthma Action Plan

Severity Classification	Triggers	Exercise
○ Mild Intermittent ○ Mild Persistent ○ Moderate Persistent ○ Severe Persistent	○ Colds ○ Smoke ○ Weather ○ Exercise ○ Dust ○ Food ○ Animals ○ Air Pollution ○ Other: _____	1.Pre-Medication (how much and when) _____ 2. Exercise Modifications: _____

GREEN ZONE: Doing Well Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

Medicine	How much to Take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

More than 80% of personal best or _____

YELLOW ZONE: Getting worse Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, tight chest
- Problems working or playing
- Wake at night

Continue Control Medications and add:

Medicine	How much to Take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 50% to 80% of personal best or _____ to _____

If your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN:

- O Take quick-relief medication every 4 hours for 1-2 days
- O Change Long-term control medicines by _____
- O Contact Physician for follow up care

If your symptoms (and peak flow, if used) Do Not return to Green Zone after one hour of the quick relief treatment, THEN:

- O Take quick-relief treatment again
- O Change Long-term control medicines by _____
- O Contact Physician/Health Care Provider within __ hours Of modifying your medication routine.

RED ZONE: Medical Alert Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Can't work or play
- Getting worse instead of better
- Medicine Not working

Control Medications

Medicine	How much to Take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 0% to 50% of personal best or _____ to _____

Go to hospital or call ambulance if

- OStill in red zone after 15 minutes
- OIf you have not been able to reach your health physician or health care provider for help.

Call ambulance immediately if following danger signs are present:

- OTrouble walking/talking due to shortness of breath
- OLips or fingernails are blue

Medical Release Form

Name of Child: _____ Age: _____ Date of Birth: _____

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I/We may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give Villa Lyan staff and faculty the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that Villa Lyan shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by Villa Lyan. I understand that this form is in effect from the date signed and that it is my responsibility to inform Villa Lyan of any changes to this form.

Signature of Mother/Legal Guardian: _____ Date: _____

Mother's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Work Phone: _____

Signature of Father/Legal Guardian: _____ Date: _____

Father's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Work Phone: _____

Pediatrician's Name: _____ Telephone Number: _____

Hospital Preference: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

Insurance Company: _____ Policy/Group #_____

Date of Minor's Last Tetanus Shot: _____ List Current Medications: _____

Allergies: _____ _____

_____ _____

Medical history or other important fact that should be known: _____

_____

Seizure Action Plan

Child's Name: _____ D.O.B: _____ Teacher: _____

Description of seizure condition/disorder: _____

_____

Describe what your child's seizures looks like: (1)What part of the body is affected (2) How long does it last?

_____

_____

Describe any known "triggers" (behavior and/or symptoms) for seizure activity: _____

_____

Detail the time and duration of child's typical seizure activity: _____

_____

Has the child been treated in the emergency room due to seizures? ☐ Yes ☐ No How many times?___

Has the child stayed overnight in the hospital due to their seizures? ☐ Yes ☐ No How many times?___

Planned Strategies to support the child's needs and safety issues when a seizure occurs:

(Diapering/toileting, outdoor play, nap/sleeping, etc)_____

_____

Problem	Treatment	Expected Response
At risk for injury due to uncontrolled seizure activity.	If seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn if prescribed.	Decrease possibility of injuries related to seizure activity.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If seizure occurs, staff will roll the child onto his/her side.	Decrease possible aspiration during seizure activity.
Self esteem disturbance related to occurrence of seizure or use of protective helmet.	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any reactions. Reassure the other children in the group that the child will be all right if a seizure occurs.	Increase child's successful adaptation to requirements of living with a seizure disorder. The child will demonstrate a positive attitude towards learning activities. Other children will feel safe.
Parent and child may not be aware of possible triggers.	Staff will document the occurrences of any seizure activity on attached seizure activity log.	Parent, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy but not responsible after seizure occurrence.	Staff will make sure that the child is responsive after seizure, then will allow the child to sleep and/or rest after seizure	The child may safely sleep/rest if needed after a seizure occurs.

Medications to be administered: ☐ Yes ☐ No *Specify administration method, time schedule, side effects*

Type of Medication: _____

_____

Additional information: *(include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)*

_____

_____

Emergency Procedure

Call 911 if:☐ Seizure is longer than _____ minutes ☐ Child is unresponsive after seizure ☐ Color changes ☐ Other: _____

Emergency Contact: _____ Telephone: _____

This Seizure Action Plan will be updated/revised whenever medications or child's health status changes.

Parent Signature: _____ Date: _____