Tappahannock Junior Academy
P.O. Box 790, Tappahannock, VA 22560
(804) 443-5076
tjaadmin@gmail.com - www.tjasda.org

List of needed items for Registration

- Registration Form (completely filled out)
- Enrollment Contract (TJA Handbook)
- Health Questionnaire / Physical (Pre-K, *K, 3, 6, & 9th grades)

  *Any new student or longer than 1 year ago
- Tdap Letter for 6th Graders
- Registration fee
- Tuition Financial Contract
- First months tuition due the first day of school
- *Records/Transcript Request
- *Birth Certificate
- *Social Security
- *Insurance Card
- *Immunization Record

If new student at TJA

Tappahannock Junior Academy
Since 1966

A Christian Alternative

Tappahannock Junior Academy
of Seventh-day Adventists

P.O. Box 790
Tappahannock, VA 22560
Phone & Fax 804-443-5076
tjaadmin@gmail.com
tjasda.org

ADMISSION APPLICATION

Tappahannock Junior Academy admits students without regard to sex, race, color, religion, national or ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of sex, race, color, religion, national or ethnic origin in the administration of its educational policies, admissions policies, scholarship and loan programs, athletics or any other school-administered program.

Date: _____ School year for which you are applying: _____-_____ Entering Grade: _____

I. Student Information:

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____/_____/_____. Sex: M / F Student Cell Phone Number _____

Students Primary Address: _____

City: _____ State: _____ Zip: _____ Phone: _____- _____-_____.

County: _____ Religious Affiliation: _____ Baptized: Y / N

Church: _____ Pastor: _____

Please check all of the following statements that apply to your child:

_____ a. Student lives with natural parent(s) or legally adoptive parent(s).

_____ b. Parents unmarried, separated, or *divorced. Student's primary residence is with: Mother / Father

_____ c. Student lives apart from parents and resides with: _____

**Please provide a copy of any custody order or decree that has been issued with respect to the student.*

II. Family Information:

Father/Guardian's Name: _____

_____ Same address as student Address: _____

City: _____ State: _____ Zip: _____ Home Phone: ___-___-____.

Father's Employer: _____ Cell Phone: ___-___-____.

Email: _____ Work Phone: ___-___-____.

Mother/Guardian's Name: _____

_____ Same address as student Address: _____

City: _____ State: _____ Zip: _____ Home Phone: ___-___-____.

Mother's Employer: _____ Cell Phone: ___-___-____.

Email: _____ Work Phone: ___-___-____.

III. Person Responsible for Registration and Tuition: _____ _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ___-___-____. Cell Phone: ___-___-____. Work Phone: ___-___-____.

Email: _____ ***Registration Payment Amt***_____

IV. Academic History: (*Please fill out section IV only if your child is a new student.*)

Please list all of the schools your child has previously attended beginning with the most recent. Please include the full address of each school. If more space is needed please provide the information on a separate sheet of paper

School Name	School Address Street or PO Box, City, State, Zip	Phone Number	Dates: From/To	Grade Completed

Tappahannock Junior Academy is not staffed to teach children with significant physical impairments, learning disabilities or behavioral issues. Please answer the following questions to help us determine if our school is right for your child.

1. Has your child ever repeated a grade for any reason? Y / N
   If yes, which grade and why? _____
2. Does your child have any visual loss, hearing difficulties, speech impediments, or physical impairments? Y / N
   If yes, please explain: _____
3. Has your child ever been referred for testing of placed in a special program for any type of learning, behavioral or mental health issues? Y / N
   If yes, please explain: _____
4. Has your child ever experienced disciplinary problems at previous schools? Y / N
   If yes, please explain: _____

The following is for all student registration:

For this application to be complete, all students must also submit the following:

- A $300 - $400 non-refundable registration fee for grades Pre-K—8th grade.
- Copy of original birth certificate
- Copy of original social security card
- Copy of transcript and records from previous schools or signed transcript release.

V. **Permission for Name and Picture Use:**

Please check all that apply.

_____ I give my permission for my child to use the internet at school for school related assignments.

_____ I give my permission for my child's **picture** to be used in the **newspaper or other publications**.

_____ I give my permission for my child's **name** to be used in the **newspaper or other publications.**

_____ I give my permission for my child's **picture** to be used on the **TJA website (tjasda.org)**.

_____ I give my permission for my child's **name** to be used on the **TJA website (tjasda.org)**.

_____ I give my permission for my child's **picture** to be used on the **TJA Facebook website**.

_____ I give my permission for my child's **name** to be used on the **TJA Facebook website**.

_____ I give my permission for my child's **picture** to be used on **TJA teacher blog website**.

_____ I give my permission for my child's **name** to be used on the **TJA teacher blog website**.

_____ I give my permission for my child's **picture** to be used in **brochures and/or DVD for promotion of TJA**.

_____ I give my permission for this phone number (_____) to be printed in the school directory.

Parent Signature: _____

VI. Members of Household:

Please list other members of your household (Brothers, Sisters, Grandparents etc.):

Name: _____ D.O.B. _____ Relationship _____

Name: _____ D.O.B. _____ Relationship _____

Name: _____ D.O.B. _____ Relationship _____

VII. Permission for Student Pick Up:

In case of emergency or unforeseen circumstances, I give my permission to Tappahannock Junior Academy to release my child to the following person(s) listed below:

Name	Address	Phone	Relationship

VIII. Physician/Dentist Information:

Family Doctor: _____ Office Phone: _____

Family Dentist: _____ Office Phone: _____

(Continued on back)

IX. Emergency, Illness and Health Information:

Does your child have any medical condition we should be aware of? _____ Yes _____ No

If yes, please indicate: _____

_____

_____Asthma
- _____ Medication
- _____ Inhaler

_____ Arthritis
_____ Deafness
_____Diabetes
_____Allergies
- _____ Bee Sting
- _____Milk
- _____ Penicillin
- _____Other _____

_____ Fractures (list)
- Date _____
- Date _____

_____ Surgeries (list)
- Date _____
- Date _____

_____ Heart Problems (list)
- Date _____
- Date _____

X. Continuing Consent to Treatment and Accident Insurance Information:

We, the undersigned parents or guardian of _____ *(student's name)*a minor, do hereby consent to any x-ray examination , anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of _____ *(name of physician)* or any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician's or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor's listed above before any other physician is called by the school.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Tappahannock Junior Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This Consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school entrusted with the custody of said minor.

Date: _____

Father: _____ Mother: _____

Signature: _____ *Signature:* _____

Phone: _____ Cell: _____ Phone: _____ Cell: _____

Legal Guardian Signature: _____ *Witness:* _____

Hospital Preference: _____ Office Phone: _____

XI. EMERGENCY CONTACT PERSON(S):

Name: _____ Relationship: _____

Home Phone: ___-___-____. Cell Phone: ___-___-____. Work Phone: ___-___-____

Name: _____ Relationship: _____

Home Phone: ___-___-____. Cell Phone: ___-___-____. Work Phone: ___-___-____

Tappahannock Junior Academy
Enrollment Contract

I, _____, have received and read a copy of the Tappahannock Junior Academy Student Handbook, which outlines the goals, policies, benefits, and expectations of TJA, as well as my responsibilities as the parent(s) / guardian(s).

I have familiarized myself with the contents of this handbook. By signing below, I acknowledge, understand, accept, and agree to comply with the information and policies contained therein.

Further, I understand my obligations in regards to, and agree to comply with, the financial policy as outlined on pages 7 – 9 of the handbook.

_____ / _____
Student Name and Signature

_____ / _____
Parent(s) / Guardian(s) Name and Signature

_____ / _____
Parent(s) / Guardian(s) Name and Signature

_____
Date

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school****. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |____|____|____|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
*Tdap booster (6th grade entry)	**1**				
*Poliomyelitis (IPV, OPV)	**1**	**2**	**3**	**4**	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
Measles, Mumps, Rubella (MMR vaccine)	**1**	**2**			
*Measles (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity:		
*Rubella	**1**		Serological Confirmation of Rubella Immunity:		
*Mumps	**1**	**2**			
*Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used	**1**	**2**	**3**		
*Varicella Vaccine	**1**	**2**	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	**1**	**2**			
Meningococcal Vaccine	**1**				
Human Papillomavirus Vaccine	**1**	**2**	**3**		
Other	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**___/___/____

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____
_____
_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[____]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	□	□	□	Neurological	□	□	□	Skin	□	□	□
Lungs	□	□	□	Abdomen	□	□	□	Genital	□	□	□
Heart	□	□	□	Extremities	□	□	□	Urinary	□	□	□

TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease
□ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: □ Positive □ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ □ Normal □ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

□ Referred to Audiologist/ENT □ **Unable to test – needs rescreen**

□ Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

Stereopsis	❑ Pass	❑ Fail		❑ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
□ **Well child; no conditions identified of concern to school program activities**
□ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** □ food: _____ □ insect: _____ □ medicine: _____ □ other: _____
Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ epinephrine auto-injector □ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). □ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) **□ By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/_____/_____

Practice/Clinic Name: _____ **Address**: _____

Phone: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____

Tappahannock Junior Academy

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Tdap BOOSTER TO BE REQUIRED FOR 6TH GRADE STUDENTS

Dear Parents of Rising 6th Grade Students

As of 2006, the Virginia General Assembly passed a law which requires all 6th grade students to have tetanus, diphtheria, peruses (Tdap) booster shot prior to entry into school, if at least five years has passed since the last shot.

Please review your child's shot record. If their last shot was before 2001 please have this done over the summer. This shot may be listed as T, Td, Dtap, and /or Tdap, call your doctor or local health department if you have questions.

Shots may be obtained from your doctor, military clinics, or the health department. Documentation should be taken to your child's school. You can find your local health department address via the Virginia Department of Health web page. On the top of the page you will find a link to local health districts with contact information for the district office.

Shots are free for both public and private school enrollment and documentation will be provided.

Thank you for your assistance.

Rev 03-03-15

Tappahannock Junior Academy

PO Box 790 – 170 Melody Court - Tappahannock, VA 22560
804-443-5076 - www.tjasda.org

Tuition and Fee Schedule
School Year: 2019-20

TUITION RATE		Annual Tuition
	First Child	$3,500.00
	Second Child	$3,200.00
	Third Child and up	$2,900.00
REGISTRATION	If Paid by:	Amount
	April 1, 2019	$300.00
	May 1, 2019	$325.00
	June 1, 2019	$350.00
	July 1, 2019	$375.00
	After August 1, 2019	$400.00
	Pre-Registration Deposit	$50.00 per student
AFTER SCHOOL CARE	3:15 pm to 5:00 pm	
	Per day, per child	$7.00
TUITION CREDITS	Refer someone to TJA and have them enroll	
	First family	$50.00 credit
	Second family	$100.00 credit
	Third family	$150.00 credit
PAYMENT PLANS		
	10 Month	$350.00 for one student
	1 Payment – 5% discount	$3,325.00 for one student

Promoting Christian Education

Tappahannock Junior Academy

P.O. Box 790
Tappahannock, VA 22560
Phone & Fax (804) 443-5076
www.tjasda.org – tjaadmin@gmail.com

_____
Date

_____
Previous School's Name

_____

_____
Previous School's Address

_____
Previous School's Phone Number

_____
Previous School's Fax Number

Dear Sir or Madam:

This is a request for all transcripts/files you have for _____.
Please send them to me as soon as possible. I would appreciate your sending all evaluative materials that apply:

a) All student records
b) Most recent IEP
c) Discipline Records
d) Grades/standardized test scores
e) Medical information
f) Copy of birth certificate and social security card
g) Any other materials pertinent to better understand this student's academic performance.

You may mail records to the above address or fax to 804-443-5076.
Please do not hesitate to call me at (804) 443-5076 if you have questions or concerns.

Sincerely,

Kim Petersen
Principal

_____ _____
Parent's Signature Date