Westfall Academy
Oh Allah, Increase My Knowledge

Westfall Academy

Islamic Center of Rochester

مدرسة وستفال الإسلامية

REGISTRATION PACKAGE 2023-2024

Address: 727 Westfall Road, Rochester, NY 14620
Tel: (585)442-0120
Fax: (585)442-9948
Email amanee.albaram@westfallacademy.org

Dear WFA Parents or Guardian or Prospective Parents:

To complete your child's registration, you will need the following:

- ☐ A copy of the child's birth certificate
- ☐ Immunization record that show that your child had:
  - ☑ DPT immunizations, 4 doses with one dose given on or after the 4th birthday
  - ☑ Polio (Tri-Valent) 3 doses with one dose given on or after the 4th birthday
  - ☑ Measles
  - ☑ German Measles (Rubella) immunizations
  - ☑ Mumps immunization
  - ☑ Hepatitis B immunization
  - ☑ Varivax (Chicken Pox) immunization
- ☐ A proof of a physical examination performed after March 1, 2019 from your child's physician or at a local clinic
- ☐ Dates of illnesses or serious accidents if any
- ☐ Please fill out all forms provided with the registration package:
  - ☑ Registration Form
  - ☑ Student Information Form
  - ☑ Medical/ Permission/ HIPAA/Release Form
  - ☑ *Release of Records Form (for new students)*
  - ☑ Home Language Questionnaire

*** Note: Students who are 3 years old on or before December 1 and potty trained are eligible to enter PreK.**

Students who are 5 years old on or before December 1 are eligible to enter Kindergarten in September.

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Registration Form

Student's Name					
Last		Middle		First	

Last Grade Attended		Student's Grade current	

New Student		Returning Student	
Last School Attended			

Date of Birth (*MM/DD/YEAR*)			

Place of Birth		Age by Dec 1st 2022		Sex	M		F	

Address		City		State		Zip	

Father's Last Name		First Name	
Mother's Last Name		First Name	
Father Email Address			
Mother Email Address			

Home Phone #											Work Phone#									
Dad cell											Mom cell									

Non-Refundable Registration Fee: $ 100.00 per child (N)		ACH ***	
		Check	
	$50.00 per child (R)	Credit	
Name of the Credit Card	CC No.		
		Expiration Date	

Parent's Signature		Date							Principal's Signature	

ACH ***: For Direct Deposit (***STRONGLY RECOMMENDED)***– please ask the office admin for an appropriate form to complete and sign. Please return the completed form back to the office for processing.

STUDENT INFORMATION

Last Name		**First Name**		**Middle**	

Date of Birth: (*MM/DD/YEAR*)									**Sex**	**M**		**F**	

Grade		**Age**	

Home Phone										

Language Spoken at Home		**Primary Language Spoken by Child**	

PARENT/ GUARDIAN INFORMATION

Father Name		Mother Name	
Address		Address	
City/State/Zip Code		**City/State/Zip Code**	

Home Phone		Home Phone	
Work Phone		Work Phone	
Cell No.		Cell No.	
Email		Email	

EMERGENCY INFORMATION

Person to Contact																					
Home Phone											**Work No.**										
Relationship											**Cell No.**										

MEDICAL/ PERMISSION AND RELEASE FORM

Student Name		**Age**		**Date of Birth**									
Address		**City**		**State**		**Zip**							
In Case of Emergency Notify													
Tel No.										**Cell No.**			
Family Physician				**Tel #**									
Family Insurance Company				**Tel #**									

Please check if received: **Immunizations**

TETANUS	**Y**	**N**	**POLIO BOOSTER**	**Y**	**N**	**MEASLES**	**Y**	**N**	**MUMPS**	**Y**	**N**	**HEPATITIS SERIES**	**Y**	**N**

PAST MEDICAL HISTORY

(Check giving appropriate information)

Asthma	Y	N	Sinusitis	Y	N	Bronchitis	Y	N	Kidney Trouble	Y	N
Heart Trouble	Y	N	Diabetes	Y	N	Dizziness	Y	N	Stomach Upset	Y	N
Hay Fever	Y	N	Stomach Ulcer	Y	N	Cancer	Y	N	Other		

Allergies	Food	
	Penicillin or other drugs (specify)	
	Insect sting/ bites	
	Poison sumac, oak, ivy, etc.	

Previous operations or other serious illnesses	

Any *CURRENT* medications: (List)						
Childhood Diseases	Chicken Pox	Y	N	Measles	Y	N
	Mumps	Y	N	Other	Y	N
Additional Medical Information						

PERMISSION FOR TREATMENT

My permission is granted for Westfall Academy designee in charge to obtain necessary medical attention and/ or hospitalization in case of sickness or injury to my child.

I, the undersigned, do hereby verify that the above-mentioned information is correct, and I do hereby release and forever discharge all sponsors and Westfall Academy form any all claim, demands, actions, past, present, or future arising out of any damage or injury while on field trips or in sports activities.

Dated this _____ day of _____ _____

State _____ City/Zip _____

Signature _____

Printed Name _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth
Patient Address	

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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RELEASE OF RECORDS

To: _____ **Date: _____**
(Previous School)

_____
(Street Address) (City/ State/ Zip Code**)**

Student Name: _____ Grade: _____ D.O.B._____

The student listed above has enrolled at Westfall Academy. Please send the academic records, health records, standardized test scores to the above address, and any confidential file. If the student left during a grading period, please indicate withdrawal grades earned for that period.

Thank You for your cooperation.

I hereby authorize _____to transfer all the school records of my son/ daughter _____ to Westfall Academy.

Parent's Signature _____ **Date: _____**

TUITION

(This policy is subject to change every year)

Full payment of tuition fees is vital to the school's operation. Tuition rates are set in accordance with the regulations set forth by the WFA Westfall Academy Education Committee (WAEC). Tuition payments are to be made directly to the ***Westfall Academy (WFA) at 727 Westfall Road, Rochester, NY 14620***. Parents are required to pay the full monthly tuition even if the child attends only one day of school.

All payments are due upon receipt of the bill by the 5th of the month. Payment reminders will go out WEEKLY for all open invoices. IF AFTER 3 WEEKS THE TUITION IS STILL NOT PAID, IT IS UPTO THE DISCRETION OF THE FINANCIAL COMMITTEE TO DISALLOW YOUR CHILD FROM ATTENDING SCHOOL. Please do not force our hand to do this. We want your child to get a quality Islamic Education but realize we have obligations to meet also, and cannot fulfill those if the tuition is not paid on time. PAYMENT POSTING POLICY: If you have invoices past due, the payment you make will first be applied to unpaid invoices and then if any amount is left it will be applied to the current invoice regardless of what invoice the payment was indented to pay.

Pre-K (3-4 yeas)	**Per month/child**		
	Regular Hours	Extended Hours	Afterschool Hours
Program Duration	8:00am-1:00 pm	1:00-3:15 pm	3:15-5:30 pm
Tuition Fees/month	$500.00 a month	$100.00 a month	$100.00 a month

Kindergarten- 5th	**Per month/ child**
Per student	$455.00 a month
After-school Care 3:15pm-5:30pm	$100 a month

A $20 per child discount will be given for each additional child enrolled at WFA.
Ask about our Automatic Payment Plan discount.

Additional Charges:
Parents are required to pay the following fees at the time of registration:

Registration Fees **$100.00 (New Student)**
$50.00 (Returning Student)

Material Fee **$300**
