HOPE CHRISTIAN ACADEMY

STUDENT ENROLLMENT APPLICATION

Early Education Department

Student Full Name:

_____

Last First MI Goes By

Date of Birth: _____ Student SS#_____

_____

Address City, St Zip

Helpful information about your student: _____

_____

Family Information:

Father//

_____

First Last

_____

Email

_____

Cell

_____

Work

_____

Employer

Mother//

_____

First Last

_____

Email

_____

Cell

_____

Work

_____

Employer

Parents are: _____Married _____Together _____Divorced _____Separated _____Mother Deceased _____Father Deceased

If parents are divorced, copy of court issued custody agreement must be provided.

If child has a safety plan because of custody situation, it must be provided.

Emergency Contacts:

Child will be released only to the custodial parents/legal guardians and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parents/legal guardians cannot be reached:

Name	Cell	Work	Relationship

Certified by FLOCS

Admin Use Only: Paperwork date _____

Start date _____

Student Medical Information:

My child takes medication on a routine basis? _____Yes _____No _____During School Hours

Name of Medication _____ Purpose of Medication _____

My child has a medical condition that may affect his/her school day? _____No _____Yes (complete next section)

My child has a condition such as asthma, diabetes, etc. (list conditions): _____

_____

My child's condition requires an inhaler, epi pen, etc. (list all that apply): _____

_____

Allergies/Special Health Considerations: _____

_____

Emergency Care Plan instructions including symptoms, medication, and notification in the event of an actual emergency (if applicable):

_____

_____

_____

_____

_____

_____

_____

Students are not permitted to carry and/or administer medication. All medication must be administered through an Early Education staff member. In the event of an emergency and I cannot be reached, I grant a representative of Hope Christian Academy permission to act on my behalf in obtaining necessary medical treatment for my child.

_____ _____ _____

Parent/Guardian Print Parent/Guardian Signature Date

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Phone: _____ Address: _____

Doctor: _____ Phone: _____ Address: _____

Dentist: _____ Phone: _____ Address: _____

Hospital Preference: _____

Certified by FLOCS

Admin Use Only: Paperwork date _____

Start date _____