

First Baptist Christian Academy Middle School Application - 2012-2013

OFFICE USE ONLY	Fees Paid			Grade
Date/Time Received:	Non-Refundable Registration Fee: \$125.00 Cash/Ck #:	Book Fee: \$175.00 Cash/Ck #:	Non-Refundable E-Key Fee: (Extended Care ONLY) \$15.00 Cash/Ck #:	Grade: 6 7 8
<input type="checkbox"/> Immunizations and Health Inventory		<input type="checkbox"/> Birth Certificate		<input type="checkbox"/> Previous Testing/School Records

Student Name: _____ Birth date: _____
Last First Middle Initial

Social Security #: **(REQUIRED)** _____ Sex: M F Race: _____

Home Phone: (____) _____ Address: _____

City/Zip: _____ Attend Church? If yes, where: _____

Public School District you live in: _____ Middle School attendance area: _____

Do you want your child's name, address and phone number listed on the FBCA Class List? Y N T-Shirt Size: _____ Home Schooled? Y N
(Please allow for growth)

Parent 1 (Mother/Legal Guardian)	Parent 2 (Father/Legal Guardian)
Name: _____ Relationship: _____ Home Phone: _____ <input type="checkbox"/> same as above Address: _____ City/Zip: _____ Employer: _____ Work Phone: _____ Cell/Pager: _____ Occupation: _____ Social Security #: _____	Name: _____ Relationship: _____ Home Phone: _____ <input type="checkbox"/> same as above Address: _____ City/Zip: _____ Employer: _____ Work Phone: _____ Cell/Pager: _____ Occupation: _____ Social Security #: _____
Parent 3	Parent 4
Name: _____ Relationship: _____ Home Phone: _____ Address: _____ City/Zip: _____ Employer: _____ Work Phone: _____ Cell/Pager: _____	Name: _____ Relationship: _____ Home Phone: _____ Address: _____ City/Zip: _____ Employer: _____ Work Phone: _____ Cell/Pager: _____

A code name is **REQUIRED**. The persons listed below will be authorized to pick up or drop off your child. They will also be contacted in the case of an EMERGENCY and the parents cannot be reached. They will need to provide proper identification. Persons not listed must provide proper identification and KNOW the code name. Please call the school office if you ask someone other than those listed to pick up your child.

Code Name: _____

Name:	Relationship:	Phone: () _____ Phone: () _____
Name:	Relationship:	Phone: () _____ Phone: () _____
Name:	Relationship:	Phone: () _____ Phone: () _____

Fall Schedule	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time					
Pick Up Time					

E-MAIL PERMISSION

I give permission for the principal and office staff of FBCA, to include my e-mail address in the electronic mailings for the school year August 2012 - May 2013.

(PLEASE print) E-Mail Address: _____

Signature: _____

I do not have access to E-mail, please send a hard copy of memos.

If new enrollment, how did you hear about our school?	<input type="checkbox"/> Friend/Family _____	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Radio
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I have read the FBCA Parent Handbook and will abide by its policies.

Parent or Guardian Signature: _____

Has your child been diagnosed with a learning or behavior disorder? If yes, please explain.

Does your child have an IEP from a previous school? Yes No If so, what school? _____

PERMISSION FOR EMERGENCY TREATMENT

By my signature below authorization is given to any FBCA staff member to consent to emergency treatment for my child, in the event that we (the parents/guardians) are not available at the time of the injury or illness. I further grant permission for the treatment of my child by the nearest emergency medical facility at the time of the injury or illness and at the discretion of the attending physician.

Parent or Guardian Signature: _____

**This section must be filled out and returned by August 15, 2012.
If we have not received this form by August 20, your child will NOT be allowed to start school until it is received.**

MEDICAL INFORMATION

Doctor Name:	Phone:
Preferred Hospital:	Phone:

Please list all medications you child is currently taking:

Does your child have:			
Allergies	Y	N	Specify:
Asthma	Y	N	Specify:
Diabetes	Y	N	Take Insulin: Y N
Epilepsy/Seizures	Y	N	Specify:
Heart Condition	Y	N	Specify:
Orthopedic Problems	Y	N	Specify:

Does your child:			
Have trouble with vision	Y	N	Have severe nose bleeds
Wear glasses	Y	N	For: Distance Close Work
Wear contact lenses	Y	N	
Have trouble hearing	Y	N	Wear a hearing aid
Take daily medications	Y	N	List medications

Has your child had:	Age	Age
Chicken Pox		Measles (Hard)
Mumps		Measles (3-Day)
Rheumatic Fever		Other:
Other:		Other:

Summary of admissions to hospital:

If child has a specific health problem, please list possible symptoms/reactions:

Should activities (including P.E./recess) be limited? Y N If yes, please explain:

Has child ever been diagnosed with any type of learning or behavioral disability? If yes, please explain:

IMMUNIZATIONS * If exempt, please attach exemption form.

Immunization	Date/Exempt*	Date/Exempt*	Date/Exempt*	Date/Exempt*	Date/Exempt*
DTP					
HIB					
Hep B					
MMR					
OPV					
Chicken Pox					

Doctor Signature: _____

Date: _____