

Student Enrollment

Date: _____ School Year: _____ Grade Entering: _____
 Tuition choose: Private Pay Step Up McKay**

Student Information

Name: _____
 (Last) (First) (Middle)
 Home Phone: _____ Family Email: _____
 Address: _____
 City: _____ State: _____ Zip Code _____
 Birth Date: ____/____/____ Age: ____ Sex: ____ Last Grade Completed: _____
 Last School Attended: _____ City: _____
 S.S.N.: _____

Parent/Guardian Information

Mother's Name: _____ **Cell Phone:** _____
 Marital Status: Married Divorced Separated Widow/Widower
 Employer: _____ Position: _____
 City: _____ Work phone: _____
 Work Hours: _____ Driver's License _____

Father's Name: _____ **Cell Phone:** _____
 Marital Status: Married Divorced Separated Widow/Widower
 Employer: _____ Position: _____
 City: _____ Work phone: _____
 Work Hours: _____ Driver's License _____

Other Household Members:

Name: _____ Age: _____ Relationship _____
 Name: _____ Age: _____ Relationship _____
 Name: _____ Age: _____ Relationship _____
 Name: _____ Age: _____ Relationship _____

Church Membership

Church attending: _____ Pastor: _____
 Address: _____ Phone: _____
 Denomination: _____ Are you active members?* **Y** or **N**

**by active membership, we mean that you are a faithful in attendance, involved in its ministries, and maintaining a good testimony.*

***If your child is on the **McKay Scholarship**, please supply the social security number of the parent listed on the application: S.S.N.: _____ - _____ - _____*

MEDICAL INFORMATION

Child's Physician: _____ Phone: _____
 Preferred Hospital: _____ Phone: _____
 Child's dentist: _____ Phone: _____
 Insurance Company: _____ Policy # _____
 Regular medications: _____
 Food Allergies: _____
 Any other Allergies: _____
 Any special Health conditions: _____

Child has had:

Measles
 German measles
 Chicken pox
 Mumps
 Whooping cough
 other: _____

Child suffers from:

headaches
 earaches
 Sore throat
 Stomach aches
 Flu/colds
 other: _____

Consent to Medical Care and Treatment of Minor Child

I, _____, hereby give permission for my child, _____, to be given emergency treatment, to include first aid and CPR by a qualified staff member of Temple Christian Academy. I further authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by his/her regular physician, or when the physician can not be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health if I cannot be contacted. In such case, I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I further authorize said center to take my child to a hospital, and agree that I will pay all physician and hospital bills, and said center will no be responsible for them.

Signature of Parent/Guardian _____ **Date:** _____

Signature of Parent/Guardian _____ **Date:** _____

Photograph Release

I release Temple Christian Academy to photograph and or videotape my child participating in daily activities, and to use the photographs and or videos in photographic displays or other publications showing these daily activities.

Signature of Parent/Guardian _____ **Date:** _____

****All students are required to have below documents on file before they can start school****
Immunization Form (blue form) and Annual Physical (yellow form)

CHILD PICK UP INFORMATION

Primary List (Parents or Guardians):

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

Please list below the people who have **Permission** to pick up your child.

NOTE: Anyone picking up your child must have picture ID.

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

EMERGENCY CONTACTS

Primary Emergency Contact (Other than parents or guardian)

Name: _____

Home phone: _____ Work Phone: _____

Relationship to Child: _____

Address: _____

Secondary Emergency Contact (Other than parents or guardian)

Name: _____

Home phone: _____ Work Phone: _____

Relationship to Child: _____

Address: _____

School administered medications

Below is a list of medications provided for students by T.C.A. Please check the box for medicine that we are allowed to administer to your child on their request:

- Tylenol Children's Tylenol Ibuprofen Children's Ibuprofen
 Tums Pepto-bismol Cough drops

By signing this you are giving the Staff at T.C.A. permission to administer above medications.

Signature: _____ **Date:** _____

Any special instructions for above medications:

