



# The Pentecostal Christian Academy

## Registration Application

**New Enrollment**    **Re-enrollment**   **School Year 20**\_\_\_\_\_   **Entering Grade**\_\_\_\_\_

Student Name: \_\_\_\_\_  
( Last Name)                      (First Name)                      (M.I)

Contact: \_\_\_\_\_  
(Home)                      (Cell)                      (Work)

\_\_\_\_\_  
(Age)                      (D.O.B)                      (Physical Defects)                      (Concerns)

Doctor: \_\_\_\_\_  
(Child's Physician)                      (Phone )

### Parent/Guardian Info

\_\_\_\_\_  
(Father's/Guardian's Name)                      (Employer)                      (Work Phone )

\_\_\_\_\_  
(Mother's/Guardian's Name)                      (Employer)                      (Work Phone )

Emergency Contact: \_\_\_\_\_  
( Name)                      (Number)

Student Grades has been:  *Superior*    *Above Avg.*    *Average*    *Below Avg.*

Has student failed any grade:  *Yes*    *No*   *If so, What grade?* \_\_\_\_\_

Reason for Selecting School: \_\_\_\_\_

School Reccommeded by: \_\_\_\_\_

Church Attending Now: \_\_\_\_\_

Attend Sunday School:  *Yes*    *No*

### ***STATEMENT OF COOPERATION***

In making application for my child it is my desire to have him/her complete the school year \_\_\_\_\_. It is also my understanding that the policy of the school is to make no refunds on registration fees. I also give permission for my child to take part in all School activities, including sports and school sponsored trips away from the school premises, and absolve the school from liability to me or my child because of any injury to my child at school or during any school activity. I will be supportive of the school and respect its policies. I will attend the Parent/Teacher Meeting (PTM) as scheduled. If I am unable to attend for reasons beyond my control, I will inform the Administration in advance. I will inform the school whenever my telephone # or address changes.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Authorization for Administration of Medication

Date \_\_\_\_\_

Student Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Grade \_\_\_\_\_ Supervisor \_\_\_\_\_

I, the parent/guardian of the student named above, give the principal/principals permission to administer the prescribed medication listed below to my child.

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

To be given \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Health condition requiring medication: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Name of Physician prescribing medication \_\_\_\_\_ Contact \_\_\_\_\_

***I understand the school personnel cannot be held liable for reactions or effects from the administration of medication. I also grant permission for school personnel to contact the physician if there are any urgent questions or concerns about medication. I have read the guidelines and agree to abide by them.***

Parent/Guardian signature \_\_\_\_\_ Contact \_\_\_\_\_

### Guidelines

\*Note: If possible, medication schedules should be arranged so all medications can be given at home.

1. Prescription medication can be administered at school. Sample medications must be accompanied by orders from the physician.
2. Over-the-counter medication can be given upon request i.e Tylenol, Aspirin, and Benadryl. Does the school have your permission to administer over-the-counter medication? \_\_\_ Yes \_\_\_ No
3. Medication must be delivered to the school office in the container in which it was purchased (dispensed). Pharmacists will give an extra labeled bottle.
4. A separate supply of medication must be keep at school. Medication will not be transported between home and school on a daily basis.
5. The label must indicate the students name, name of medication, physicians name, dosage, frequency, and date.

