



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 Recommended 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 _____



The Pentecostal Christian Academy

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.