FELLOWSHIP CHRISTIAN ACADEMY

16425A Old Richmond Rd., Sugar Land, TX 77498
(281) 495-1814 (281) 495-1831 Fax

ADMISSION INFORMATION

Present date ______________ Starting Date _______________ Grade ______________

Child's Full Name ____
First Middle Last Answers to

Date of Birth ___/___/___ Male ____Female____

PARENT/GUARDIAN # 1

Mr/Mrs/Ms _____________________________________ Home Phone _________________

Home Address __________________________________ Lives with student? Yes No

City/State/Zip __________________________________ Billing Party Yes No

Relation to Student _______________________________ Cell Phone___________________

Employer/Occupation _____________________________ Work Phone _________________

E-mail ____

PARENT/GUARDIAN # 2

Mr/Mrs/Ms _____________________________________ Home Phone _________________

Home Address __________________________________ Lives with student? Yes No

City/State/Zip __________________________________ Billing Party Yes No

Relation to Student _______________________________ Cell Phone___________________

Employer/Occupation _____________________________ Work Phone _________________

E-mail ____

____ ____________________________

Signature of Parent/Guardian Date

School Year: 2010 - 2011

Child's Name:______________________

Other than parents, ***CHILD WILL BE RELEASED ONLY TO PERSONS INDICATED BELOW*** (Must include at least TWO local persons to call for illness, accident, late pick-up, or other emergency reasons). Please list them in the order of preference for us to contact.

Mr/Mrs/Ms ______________________________________ Home Phone ____________________

Home Address ___________________________________ Lives with student? Yes No

City/State/Zip ___________________________________ Billing Party Yes No

Relation to Student ________________________________ Cell Phone______________________

Employer/Occupation ______________________________ Work Phone ____________________

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Mr/Mrs/Ms ____ Home Phone ______________________

Home Address ______________________________________ Lives with student? Yes No

City/State/Zip ______________________________________ Billing Party Yes No

Relation to Student ___________________________________ Cell Phone _______________________

Employer/Occupation _________________________________ Work Phone ______________________

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Mr/Mrs/Ms ____ Home Phone ______________________

Home Address ______________________________________ Lives with student? Yes No

City/State/Zip ______________________________________ Billing Party Yes No

Relation to Student ___________________________________ Cell Phone _______________________

Employer/Occupation __________________________________ Work Phone ______________________

Family Information

Names and ages of other children in the family ____

Has your child ever been in school before? ______ If yes, where __________________________________

Church membership or religious preference ____

Photograph Release

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

____ ________________________

Signature of Parent/Guardian Date

School Year: 2010 - 2011

EMERGENCY INFORMATION

Child's Name__________________________ Birthdate______ Weight______

Address____

City________________________________ State__________ Zip__________

Home Phone ________________________ Cell Phone____________________

Father's Name__________________________ Daytime Phone_____________
Cell Phone________________

Mother's Name__________________________ Daytime Phone_____________
Cell Phone________________

Emergency Contact_______________________ Daytime Phone_____________
Cell Phone________________

Consent to medical care and treatment of minor child

I, _________________________, hereby give permission that my child _________________________, may be given emergency treatment, to include first aid and CPR by a qualified staff member of Fellowship Christian Academy. I further authorize and consent to medical, surgical and hospital care, treatment, and procedures to be performed for my child by my child's regular physician, or when that physician cannot 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 a case, I waive my right to 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 I agree that I will pay all physicians and hospital bills, and said center shall not be responsible for them.

____ _____________________

Signature of Parent/Guardian Date

School Year: 2010 – 2011

Child's Name__________________

Medical Information

Known allergies to medications and other substances

____

____

Are there any restrictions on normal physical activities indicated?

___ Yes ___ No

If yes, please specify:____

Does the child have any chronic medical conditions necessitating dietary supplements or restrictions, medication, or avoidance of allergens?

___ Yes ___ No

If yes, please specify:____

Does the child have any known allergies? ___ Yes ___ No

If yes, special attention required:____________________________________

Does the child have asthmatic problems? ___ Yes ___ No

If yes, special attention required: ____________________________________

Hospital Preference____

Insurance Carrier____

Group Number________________Policy/Individual Number________________

Child's Doctor_________________________________ Phone_______________

Address____

Child's Dentist_________________________________ Phone_______________

Address____

_____________________________________ ___________________________

Signature of Parent/Guardian **Date**

School Year: 2010 – 2011