



ST. CLOUD CHRISTIAN ACADEMY
2023-2024 APPLICATION FOR ADMISSION

FOR OFFICE USE ONLY:

SID: _____

Tag #: _____

Student Name: _____ Gender: Male: ____ Female: ____
Last Name, First Name, Middle

Date of Birth: ____/____/____ Age: ____ Years ____ Months SSN: _____ School Grade Enrolling: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Dismissal Procedure: Walk () Bicycle () Car () Onsite Aftercare () Other: _____

Who does the student live with? (circle one) Mother/Father/Both parents/Other

Primary Parent/Guardian Information

Mother / Father / Other: _____

Name: _____

Address: (if different from student) _____ Apt#: _____

City: _____ State: _____ Zip: _____ Email: _____

Employer: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Ext: _____

Other Parent/Guardian Information

Mother / Father / Other: _____

Name: _____

Address: (if different from student) _____ Apt#: _____

City: _____ State: _____ Zip: _____ Email: _____

Employer: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Ext: _____

Siblings

Does the student have siblings who attend SCCA?

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

LEGAL DOCUMENTS

Who has custody of the student? (Please circle) Mother/Father/Both parents/Other

Are there legal custody restraint documents? _____ Yes _____ No

If yes, please make available all legal documents for school office record.

LANGUAGE / EDUCATION INFORMATION

Language Information

Is English the primary language spoken in the household? _____ Yes _____ No

If no, what language is the primary language? _____

Is the family able to communicate in English? _____ Yes _____ No

The school will attempt to provide translation; however, if necessary, the family must provide a translator for communication and participation of activities.

Educational Background

Please fill in the name and address of the school the student is currently attending:

Name of School: _____

Address: _____ City: _____ State: _____ Zip: _____

Does the student have a current IEP or 504 Plan? ____ Yes ____ No Exceptionality: _____

Has the student ever repeated a grade? ____ Yes ____ No Grade: _____

Has the student ever been suspended, expelled, arrested, or on probation? ____ Y ____ N

If yes, what grade and explain: _____

EMERGENCY CONTACTS / ALTERNATE PICK-UP PERSONS

(Two people other than parents. Must be 18 years or older. Must show Florida ID)

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

HEALTH / ALLERGY INFORMATION

Does the student have any health/physical/emotional/learning difficulties for which he/she has been diagnosed and/or is being treated for, and of which the school needs to be aware of? _____ Yes _____ No

If yes, please explain: _____

Please list any chronic/severe illnesses, injuries, surgeries, etc. that the student has?

Does the student take any medication? _____ Yes _____ No

If yes, please list them here: _____

Does the student have any allergies? _____ Yes _____ No

If yes, please list: _____

Does the student have an EpiPen prescribed? _____ Yes _____ No

In case of emergency, please list your hospital preference: _____

Prescribed or over the counter medication that needs to be administered to the student during school must be accompanied by a Medication Authorization Form completed by the Doctor. All medication must be within expiration dates. Please be advised that cough drops are considered over the counter medication. The school is unable to provide any medication to our students.

**If there are changes to any information above, please notify the office immediately.
This application does not guarantee enrollment of the student.**

*I confirm that all information provided is true and accurate and will notify the school in writing if any information changes.

Parent Signature

Date



St. Cloud Christian Academy MEDICAL LIABILITY RELEASE FORM

PLEASE PRINT ALL INFORMATION

If my child _____ becomes ill or injured while at school or during school sponsored activities, or during summer camp, I give consent for the school authorities to take the following steps.

1. Contact emergency services (911) to secure medical assistance.
2. Contact the child's physician and follow his / her instructions.
3. Contact me as the child's parent and inform me of the situation.

In the event I cannot be reached, I empower, authorize, and appoint the principal or his / her designee to furnish on my behalf written and or oral authorization to secure the medical services as soon as needed to assist my child.

I further release the principal, designee and school from liability which might arise from giving such authorization.

Child's primary source of health care is:

Physician/Clinic Name: _____ Phone Number: _____

Please list any medications that the student is currently taking: _____

Please describe completely any medical condition which may recur or be a factor in medical treatment:

- | | |
|-------------------------------|-------------------------------|
| a. Allergies: _____ | e. Physical Handicap: _____ |
| b. Convulsions: _____ | f. Medicine Reactions: _____ |
| c. Blackouts: _____ | g. Disease of any kind: _____ |
| d. Heart/Lung Problems: _____ | h. Other (be specific): _____ |

Insurance Information:

Health Insurance: _____ Provider: _____

Policy No.: _____ Group Family No.: _____

- ☐ My child does not have medical insurance (**Please fill out backside of form**)

PARENT/GUARDIAN: Please check one of the following and sign your name.

- ☐ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.
- ☐ I do **NOT** give permission for medical treatment until I have been contacted.

Parent/Guardian's Print: _____

Parent/Guardian's Signature: _____ Date: _____



ST. CLOUD CHRISTIAN ACADEMY
NO MEDICAL INSURANCE FORM

To whom it may concern,

Date: _____

I, _____ certify that my child _____,
(Parent's Name) (Child's Name)

is not covered under any form of medical insurance. If in the future I obtain medical coverage, I will submit all pertinent information to St. Cloud Christian Academy. In the meantime, I understand that I will be responsible for all medical bills associated with care of my child.

Parent's Signature

Parent's Signature