ENROLLMENT APPLICATION 2018-2019 SCHOOL YEAR

Application Date: ________ Grade Applying For: ________ Previous School: ____________________________

Student's Name: ____ DOB: ______/_____/______
First Middle Last

Present Address: ____Phone (_____)______-______

City ____________________________State __________ Zip Code __________ Re-enrollment ❑ Yes ❑ No

Father/Guardian's Name: _________________________

Fill out if different from above:

Address: ____

City: ______________________State_____ Zip _______

Home Phone: (______)______-_______

Cell Phone:(______)_______-________

E-mail Address: __________________________________

Occupation:

Employer: ____

Business Address: _________________________________

Business Phone: (______)_______-________

Mother/Guardian's Name _________________________

Fill out if different from above:

Address: ____

City_____________________ State ______ Zip________

Home Phone:(______)_______-________

Cell Phone: (______)________-________

E-mail Address: __________________________________

Occupation:

Employer: ____

Business Address: _________________________________

Business Phone: (_______)_______-________

School Emergency Authorization Form

I hereby authorize the Rock County Christian School to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified physician, called by the Rock County Christian School may treat and perform whatever medical procedure is necessary for the health and well being of my child.

It is understood that a conscientious effort must be made to notify me(parents)before such action will be taken.

I hereby consent to have my child participate in field trips and activities supervised by the staff - away from the school grounds.

Your signature grants permission for the additioinal contacts listed below to remove your child from school if needed for illness or injury. You may also give permission on the day of the incident for others to remove your child.

#1Primary Contact: ____
(other than parent) Name/Address Home Phone Work Phone Relationship

#2Alternate Contact:____
(other than parent) Name/Address Home Phone Work Phone Relationship

____
Parent/Guardian Signature Date

Medication: I hereby authorize Rock County Christian School to administer the following non-prescription medication to my child as needed and not to exceed the recommended dosage according to instructions:

____

Allergies: Rock County Christian School needs to be aware of the following items that my child is allergic to:

____

Parent/Guardian Signature:____Date:___________________

In case of medical emergency 911 will be called

Student Photo if available

PRN or As Needed Medication Record

Student's Name: ________________________________ Grade/Classroom:________________
Name of Medical Provider:________________________ Phone Number: _________________
When to be given:_______________________________Route:__________________________
Start Date:_____________________ Stop Date:_______________________
Special Considerations:____

Enter time medication given/Initials

Date	Time	Medication Given	Initials

Delegating School Nurse: __________________________________ Initials: _______

School personnel authorized to administer medication:

1. __________________________________ Initials: _________
2. __________________________________ Initials: _________
3. __________________________________ Initials: _________