Roxboro Christian Academy

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**$25 Application Fee due upon submission

K3-K4 Application
20___ - 20___

Please provide the following information about your *CHILD*:

Last Name: _____ First Name: _____ Middle Name: _____
Age: _____ Sex: _____ Applying to Grade: _____ DOB: _____
Child's Physical Address: _____
Child lives with: _____

Please provide the following information about *YOURSELVES*: (circle one)

Parent 1: (I.E. Father, Mother, Stepfather, Stepmother, Grandfather, Grandmother, etc.)

Last Name: _____ First Name: _____ Middle Name: _____
Street Address:_____
City: _____ State: _____ Zip:_____
Cell #: _____ Home #: _____ Email Address: _____

Parent 2: (I.E. Father, Mother, Stepfather, Stepmother, Grandfather, Grandmother, etc.)

Last Name: _____ First Name: _____ Middle Name: _____
Street Address:_____
City: _____ State: _____ Zip:_____
Cell #: _____ Home #: _____ Email Address: _____

Child will be released only to the parent/guardians listed below. The child can also be released to the following individuals, as authorized by the person who signs the application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Please provide the following *emergency contact information*:

Primary Emergency Contact (other than Parent 1 or 2):
Last Name: _____ First Name:_____
Relationship to Student: _____
Home #: _____ Cell #: _____
Work #: _____ Email: _____

Secondary Emergency Contact (other than Parent 1 or 2):
Last Name: _____ First Name:_____
Relationship to Student: _____
Home #: _____ Cell #: _____
Work #: _____ Email: _____

Health care needs:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached: _____ Yes _____ No

List any allergies and the symptoms and type of response required for allergic reactions: _____

_____

List any health care needs or concerns, symptoms of any type of response for these health care needs or concerns:

_____

_____

List any particular fears or unique behavior characteristics the child has: _____

_____

List any types of medication taken for health care needs: _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child:

_____

Emergency Medical Care Information:

Name of health care professional: _____ Office Phone: _____

Hospital preference: _____ Phone: _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian: _____ Date: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Preschool Director: _____