



A Foundation of Children United to Succeed, Inc.

“Developing A Future of Possibilities”

“And they were bringing children to him that he might touch them ...” (Mark 10:13-14)

Rites of Passage

Student Information

Student ID

Date of Birth

Address

City/State/Zip

Phone

Parent Information

Parent Name

Phone Number(s)

Work

Cell

Email Address

Emergency Contact Person

Relationship to Student

Phone Number(s)

Work

Cell

Persons ALLOWED to Pick Up Student

Phone Number

Persons NOT ALLOWED to Pick Up Student



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BEHAVIOR MANAGEMENT POLICY

Your child is expected to behave appropriately at all times and follow the rules of F.O.C.U.S. Homeschool Summer Academy

Parent Initials

- I understand that if my child does not follow the rules he or she will receive a verbal warning.
 I understand that if the misbehavior continues, I will receive a phone call about my child.
 I understand that if the problem continues, my child will be dismissed from the program.
 I understand that fighting and/or inappropriate sexual behavior will result in immediate dismissal from the program.

ALL INFORMATION IS COMPLETELY CONFIDENTIAL

I am the parent or legal guardian of the minor named above and has legal authority to execute this consent and release.

Confidential Student Health & Emergency Information

Physician Information _____

Physician Name

Street Address

City

Zip Code

Phone Number

Hospital



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LIST ALL MEDICATIONS CURRENTLY TAKEN BY CHILD

Please check all of the medical conditions that apply to your child. Please explain those checked in the space provided. Information will be shared with CISD. Copies of the care plan should go to all the student’s teachers, coaches, transportation office (if applicable), food service (if applicable) personnel on a need to know basis.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Food or Insect bite Allergies | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Earaches/Tubes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Genetic Disorder |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Heart/Lung Condition | <input type="checkbox"/> Hyperactivity and/or ADD |
| <input type="checkbox"/> Metabolic Disorder | <input type="checkbox"/> Mobility Impaired | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Special Education Services |
| <input type="checkbox"/> Vision Impaired | | |
| <input type="checkbox"/> Other: | | |

Explanation:

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:

In the event physician or parent cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I, the undersigned, do hereby authorize A Foundation of Children United to Succeed, Inc and it’s affiliates to contact directly the person named on this document, and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of the child.

Parent / guardian Signature

Date