The Christian Academy of Winter Haven, Inc.

P.O. Box 3515, Winter Haven, FL 33885

Elder Larry Hart, Superintendent
Sister Patricia Kilpatrick, K-6th Grade Principal

Elder Kenneth Brascom, Administrator
Sister Inez Brunson, 7th-12th Grade Principal

"We Walk By Faith...Not By Sight."

REGISTRATION FORM K - 12

☐ **New Enrollment** ☐ **Re-enrollment**		**School Year: 20___ - 20___ Grade to Enter: ___**	
Student's Name: Last:		First:	Middle:
Street:		City:	Zip:
Phone:	Birth Date: / /		Student's Race:
School attended last year:	Address:		Emergency Information List contact if parent cannot be reached
Circle grades previously attended at this school: K5 1 2 3 4 5 6 7 8 9 10 11			Name:
Father's Name:	Phone:	Employer:	Phone: Child's Physician's Name:
Email:		Ph#	
Mother's Name:	Phone:	Employer:	Phone:
Email:		Ph#	Additional Contact:
List the parent/guardian with whom the student lives:			Church now attending:
Reason for selection of this school:			Attending Bible School? ☐ Yes ☐ No
School recommended by:			
Principal's Signature:			Date:

Statement of Cooperation

In making application for my child, it is my desire to have him/her complete the school year _____. It is also my understanding that the policy of the school is to make no refunds on registration fees. I also give permission for my child to take part in all school activities, including sports and school sponsored trips away from the school premises, and absolve the school from liability to me or my child because of any injury to my child at school or during any school activity. I give permission for my child to be photographed for the purpose of the Christian Academy of Winter Haven, Inc. website, publications, school newspaper, and social media platforms. I will be supportive of the school and respect its policies. I will attend Parent/Teacher meetings (PTM) as scheduled. If I am unable to attend for any reason beyond my control, I will inform the school whenever my telephone # or address changes.

Parent Signature: **Date:**

Please complete the back of this Registration Form

The Christian Academy of Winter Haven, Inc.

Questionnaire

1 Please list any special living situations of this student that the school needs to be aware of?

_____

_____

2 Does your child frequently speak any language other than English? Yes No

If so, please list them _____

_____

3 New enrollees only: Has your child primarily experienced learning at school or home?

Home School Other _____

4 Does your child plan to participate in any extracurricular activities, requiring him or her to leave school property early? Yes No

If so, please list the sport _____

Please list the school _____

5 Does your child have any diagnosis or limitations that may hinder him/her in class? Yes No

If so, please list them _____

_____

_____

6 Does your child require a packed lunch from home for any reason? Yes No

Permission to Pick up this student:		
Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**

School Nurse Consent for Treatment/Emergency Information

OVER-THE-COUNTER MEDICATIONS
(Provided by the parent/guardian or if available)

The following are available to all students whose consent forms have been signed/returned:
Cross out any over-the-counter medications below you DO NOT want your child to receive.

-Acetaminophen (Tylenol)
-Midol (only for students aged 12 and older)
-Burn Cream
-Topical Antiseptic (Benzalkonium Chloride)
-Hydrogen Peroxide
-Diphenhydramine (Benadryl)
-Topical Mouth/Tooth Pain Relievers (Orajel/Anbesol)
-Ibuprofen (Motrin)
-Hydrocortisone Cream 1%
-Cough Drops/Throat Lozenges
-Antibiotic Ointment
-Eye Wash, Irrigating Solution
-Tums

Reminders:

- The medications listed above will only be given by School Nurse or by instructions given to staff member, after examination of symptoms.
- These medications cannot be given for more than three days in a row without a note from your child's healthcare provider.

Check if your child has any of the following:

My child has the following life-threatening condition that may need emergency treatment or medication (EpiPen, glucagon, emergency seizure medications, asthma inhaler, etc.) at school:

[ ] Asthma [ ] Diabetes [ ] Seizure [ ] Dietary Needs (including food allergies)
[ ] Allergy (to something other than food) [ ] Other Health Conditions (not listed above)

List any allergies: _____

Medications (RX): _____

_____

CONSENT FOR HEALTH SERVICES: I consent to care for my child that may include treatment, first aid, over-the-counter medications as listed on the Consent for Treatment form, and any other health services given to my child by the School Nurse. I understand that I have the right to decline consent for health services. I understand that no guarantees are being made as to the effect of any exam or treatment on my child.

_____

Signature: _____ Date: _____

I decline consent for any treatment/first aid/over-the counter medications by the School Nurse.

Signature: _____ Date: _____

(Parent/Guardian) (Expires in one year)

PLEASE RETURN TO SCHOOL