The Frazer School

_____ SCHOLARSHIP ENROLLMENT CHECKLIST

Student's Name:_____ Date:_____

_____Complete Enrollment Application

_____Read Over AND sign Parent Agreement

_____Read over AND sign Tuition and Fees Schedule

_____Complete Student Medical History Form

_____Enrollment Fee *($150 – not covered by scholarship)*

Please provide a copy of the following items (NEW STUDENTS):

_____Immunization Record (and/or fully executed Medical or Religious exemption State of Florida form)

_____Birth Certificate

_____Copy of Social Security Card

_____Student's Medical Insurance Card

_____Parent's or Guardian's driver's license

_____Driver's license of anyone authorized to pick student up from school

_____Student's driver's license and insurance card (*only if student will be driving to and from school.)*

_____Student's School Entry Health Exam Form

_____Student's Record of Scoliosis Screening *(7th Grade & up)*

_____Scholarship Award Letter

_____Sports Physical *(if applicable)*

The school office must have these copies prior to the first day of school

Thank you,

The Frazer School

Tuition & Fees Schedule In House Scholarship Plan

Grades 3-12th

_____ is approved for a In House Scholarship
that Student's Name pays The Frazer School
$ 8,000 per year.

The Frazer School Tuition Rates:

All Students

Tuition	$10,000

Parents must submit a check for $2,000 made out to The Frazer School when they submit their child's application. If your check is deposited then you are accepted into our school. Those not accepted will have their checks returned.

Any student who otherwise qualifies for entry into the school but will have difficulty meeting the financial requirement will, with proper documentation, be given a reduced fee.

Tuition will not be reimbursed if the student withdraws during the school year. I/We, the parent(s), agree to meet the financial obligation outlined above and will submit to the school's requirements.

Father's Signature or Legal Guardian Mother's Signature or Legal Guardian

Date Date

STUDENT INFORMATION

LEGAL NAME
OF STUDENT: _____ _____ _____
Last First Middle
Nickname: _____

Gender Birthday Place of Birth Age _____
Male___ Female_____ ___/___/____ _____
___

Grade last attended:_____ Grade Applying for:_____

Name and Address of _____
Last School Attended: _____

PARENT INFORMATION

FATHER

Name: _____
Address:_____

Home Phone:_____Cell Phone:_____
E-Mail:_____
Occupation: _____
Employer: _____Work Phone: _____

MOTHER
Name: _____
Address: _____

Home Phone:_____Cell Phone: _____
E-Mail:_____
Occupation: _____
Employer: _____Work Phone: _____
Student lives with:_____Both Parents _____Mother _____Father
_____Step-Mother _____Step-Father _____Grandparent(s)

IMPORTANT: If you are legally separated or divorced and your current or former spouse is legally prohibited from seeing or removing your child from school, you MUST provide our office a certified copy of the relevant court order

PERSONAL INFORMATION FORM

On average, how many hours per day does the student spend on screens not related to school work? _____

How would you rate your child's work ethic on a scale of 1-5 with 1 being very poor and 5 being very strong? _____

Our school is focused on academic competition and all students grades 6-12 are expected to compete on at least one academic team. Please check all academic teams that you are interested in.

Math ____
Science_____
Speech & Debate_____
History/Quiz Bowl _____
Robotics _____
Foreign languages_____
Geography_____

Other_____

Do you have any other intellectual competitions that interest you (ex. Chess or bridge) Do not list musical or sports interests here.

Has student been expelled or suspended from any school?____Yes ___No
If yes, please explain.

Authorization for Emergency Care

In case of accident or serious illness and the school is unable to reach a parent/guardian, I hereby authorize the school to contact the physician indicated on the emergency form and to follow their instructions. If it is impossible to contact this physician, the school may make whatever arrangements necessary to provide care and treatment for my child.

In case of an accident or serious illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at the school, the school will contact a parent/guardian to arrange transportation for my child. If the school is unable to reach a parent or guardian, I authorize the school to contact one of the persons listed on the emergency form and request them to come to the school and transport my child.

Medication Policy

No medication may be given to a child by any staff member of the school unless a separate Medication Authorization Form is completed. This includes prescription and non-prescription medication. Before any medication can be administered, a statement from the physician or parent concerning the medicine, the dosage and time administered, must be on file at the school. All medicines are to be sent to the school office and clearly labeled. **NO STUDENT MAY HAVE ANY MEDICINE ON HIS OR HER PERSON OR IN HIS OR HER BELONGINGS AT ANY TIME**.

General Release of Liability

The undersigned hereby releases and forever discharges The Frazer School and employees, from all claims and demands, rights, and causes of action of any kind the undersigned now has or hereafter may have on account of or in any way arising from personal injuries known or unknown to the undersigned at the present time and property damage resulting or that results from any occurrence which may happen to our child (ren), during his/her stay at The Frazer School Parent Authorization

Please initial each appropriate box and sign accordingly.

_____1. **Parent/Student Handbook**
I agree to read the student handbook and will support the policies as described, including, but not limited to, school discipline code and conduct code.

_____2. **The Frazer School Volunteer Requirements**
The Frazer School requires that all volunteers must be fingerprinted and have a Background check completed. There are no exceptions.

__3. **Financial Responsibility**
I assume the total financial responsibility of tuition and fees for the school year and understand that all tuition and fees paid are non-refundable. I agree to pay tuition according to the published schedule for the school year. Payments must be made in order to maintain student status.

Parent/Guardian Signature:_____Date:_____

EMERGENCY INFORMATION FORM

Please note: When a student is in need of emergency medical attention, the office will call 911, the Parent, and family doctor (in that order). In situations that are not emergencies, the parent will be notified.

Student Name: _____
Name of Doctor:_____Phone #_____
Insurance Company:_____Policy #_____Phone #_____ Policy Holder Name: _____

ALLERGIES OR SERIOUS ILLNESSES:_____Yes _____No
If yes, Please explain.

EMERGENCY CONTACT NUMBERS

Please make sure the numbers you give us are current and the BEST ones to reach you. Please include area code. Also, you will need to notify us **IMMEDIATELY** of any phone number changes.

Mother:
Home#_____Cell#_____Work#_____
Father: Home#_____Cell#_____
Work#_____

Please let us know whom you would like us to contact in the event you cannot be reached. Please list these contacts in the order you would like us to make contact.

Emergency Contact Name: _____
Relationship:_____ Home
or Cell#_____
Work#_____ Email:
_____

Emergency Contact Name: _____
Relationship:_____ Home
or Cell# _____
Work#_____ Email:
_____

Emergency Contact Name: _____
Relationship:_____ Home
or Cell#_____
Work#_____ Email:
_____

"All information provided by the family for this student will be protected by the school personnel who will use it only for the benefit of the student entrusted to the school. It will be shared only with appropriate emergency medical or law enforcement personnel if the school administration deems it necessary."

EMERGENCY MEDICAL AUTHORIZATION

Purpose: To ENABLE parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

STUDENT INFORMATION

Student's Name	Birthday	Blood Type	Grade	Home Phone
Street	City			Zip Code
Father's Name	Occupation			Business/Cell Phone
Mother's Name	Occupation			Business/Cell Phone
Emergency Contact Name/Phone				Emergency Contact/Phone
Medical Insurance Carrier	Policy Number			

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)
In the event reasonable attempts to contact me at_____ or _____
Primary Phone Number Secondary Phone Number

Have been unsuccessful, I HEREBY GIVE MY CONSENT for (1) the administration of any treatment deemed necessary by

Dr._____ Or Dr._____
Primary Physician Primary Dentist

Or, in the event the DESIGNATED preferred practitioner is not available, byanother licensed physician or dentist; and (2) the transfer of the child to _____
Preferred Hospital

Or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

PARENT SIGNATURE:_____
Father/Guardian Mother/Guardian Date

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II (REFUSAL TO CONSENT)
I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to TAKE NO ACTION OR TO:

SIGNED: Father/Guardian_____ Mother/Guardian_____ Date:_____

MEDICAL INFORMATION

Diagnosis (for example, Asthma)	Medication	Dosage	Frequency

Is student currently taking medication on a regular basis? If yes, please specify in the box below.

Has student *ever* taken Ritalin, Adderall or a psychoactive drug?_____Yes____No
Is Student *currently* taking Ritalin, Adderall or a psychoactive drug?___Yes__No

Please list current PRESCRIPTIONS your child is taking (Medication prescribed by a physician)

NON-PRESCRIPTION (over-the-counter medication)

Condition	Medication	Dosage	Frequency

Please refer to the school handbook for medication policy. Medication forms are available in the office.

Does your child have allergies?_____If yes,
please specify_____

Does your child have asthma? If yes, what is the
current treatment?_____

I_____acknowledge that I have completed the application,
student (Print First and Last Name)

enrollment and medical information forms to the best of my knowledge. If any information changes I will notify the school office in writing as soon as possible

Parent/Guardian Signature_____Date:_____

Authorization for Administering Medication at School
(Prescription or Non-Prescription)

Student Name:_____

Grade:_____

I request that a person delegated by the school Principal give my child,

_____, the following medication:
(Child's Name)

Name of Medication	
Amount to be given	
Time of day to be given	
Prescribing Physician	
Physician Phone Number	
Illness/condition prescribed for	
Dates medicine is to be given	From: To:

Prescription medicine**: MUST** have the original prescription label on the container; this label will include the child's name, medication, amount, frequency of administration, doctor's name, pharmacy's name and phone number.

Non-prescription medicine: MUST be in original container and marked with the student's name.

I agree to furnish the school with this medication in the bottles as described above. I further understand that the school-designated person will administer this medication to my child in good faith, at my request.

Signature of Parent/Guardian Date

Printed Name Parent/Guardian

Contact Information: Phone Numbers

Home:_____ Mom Cell:_____ Dad Cell:_____

Mom Work:_____Dad's Work:_____Primary E-mail:_____

CHILD DROP-OFF AND PICK-UP AUTHORIZATION

Today's Date _____

For the safety of our students this form must be completed and retuned to TFS office.

CHILD'S NAME (Please print) _____Child's Current Grade_____
Parent's Signature/Legal Guardian Signature _____

NO ONE WILL BE PERMITTED TO PICK UP YOUR CHILD IF THEIR NAME IS NOT LISTED BELOW. WE MUST HAVE PICTURE ID ON FILE OF EVERYONE ON THIS LIST.

THE FOLLOWING ADULTS ARE AUTHORIZED TO PICK-UP MY CHILD FROM SCHOOL

1. Parent/Guardian (Please Print)_____

Work Phone _____ Cell Phone_____ Home Phone _____

Address _____City_____State_____

2. Parent/Guardian (Please Print) _____

Work Phone _____ Cell Phone_____ Home Phone _____

Address _____City_____State_____

PERSON(S) OTHER THAN PARENT/GUARDIAN AUTHORIZED TO PICK UP AND/OR DROP OFF CHILD

1. Name (Please Print) _____

Work Phone _____ Cell Phone_____ Home Phone _____

Address _____City_____State_____
Relationship: Grandparent Relative Family Friend Daycare Provider

2. Name (Please Print) _____

Work Phone _____ Cell Phone_____ Home Phone _____

Address _____City_____State_____

Relationship: Grandparent Relative Family Friend Daycare Provider

3. Name (Please Print) _____

Work Phone _____ Cell Phone_____ Home Phone _____

Address _____City_____State_____

Relationship: Grandparent Relative Family Friend Daycare Provider

RELEASE OF INFORMATION

Name of Previous School

Student Name

Address

Date of Birth

City, State, Zip Code

The Frazer School
Name of Present School

The parents of the above-named student have given permission for receiving information from you regarding school transcripts, health records (including all immunization records), and diagnostic (psychological or mental), and educational evaluations for their child. A summary of your contacts with the student and family would also be helpful. These records will be used to determine the student's appropriate educational program. Please include grade/credit explanation for high school courses.

Parent
Consent for Release of Information

I hereby give my permission for release of the following records:

_____1. Psychological Evaluation
_____2. Educational Evaluation
_____3. Medical Evaluation/Health Records
_____4. Grades/Educational Tests
_____5. Current Withdrawal Grades

_____ _____
Parent/Guardian Signature Date

_____ _____
Student Signature (if 18 or older) Date

Please return to:
The Frazer School
3724 SW 65th lane
Gainesville, FL 32608