



ABA Hanes City
 116 N 22nd St
 Haines City, FL 33844
 863-353-8661
Abac82014@gmail.com
www.abafl.org

“Forming Lives Today for a Blessed Tomorrow”

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|---|--|
| <p align="center">OFFICE USE ONLY:</p> <p>DATE RECEIVED: ____/____/____</p> <p>Reg Fee: _____ Cash __ Debit __ Check # _____</p> <p><input type="checkbox"/> Physical Forms</p> <p><input type="checkbox"/> Vaccines</p> <p><input type="checkbox"/> Birth Certificate</p> <p><input type="checkbox"/> Medication Authorization</p> <p><input type="checkbox"/> Scholarship letter _____</p> <p><input type="checkbox"/> Payment Plan</p> <p><input type="checkbox"/> Paid in Full</p> | <p>Grade Entering: __ Student Id: _____</p> <p>New __ Returning __ Sibling __ Other _____</p> <p><input type="checkbox"/> Transcript/Grades</p> <p><input type="checkbox"/> FSA Testing</p> <p><input type="checkbox"/> IEP/504</p> <p><input type="checkbox"/> Withdrawal Form</p> <p><input type="checkbox"/> Special Needs/ Medical Diagnosis</p> <p><input type="checkbox"/> Extended Care __am (or) __ pm</p> <p><input type="checkbox"/> Interviewed by: _____</p> |
|---|--|

STUDENT INFORMATION

DATE:

| | | | |
|--|-------------------------|---|-----------------|
| LAST NAME: | FIRST NAME: | MIDDLE NAME | PREFERRED NAMED |
| STUDENT SSN# | CHILD’S BIRTHDATE: | BIRTHPLACE: | GENDER: |
| RESIDENCIAL ADDRESS: | | | |
| CITY | ZIP CODE | HOME PHONE: | |
| APPLYING TO GRADE: | COUNTRY OF CITIZENSHIP: | STUDENT’S NATIVE LANGUAGE: | |
| STUDENT LIVES WITH: | | SIBBLINGS: NAMES/ AGE & GRADES | |
| IS A LANGUAGE OTHER THAN ENGLISH USED IN THE HOME? | | HAS STUDENT BEEN IDENTIFIED AS EXCEPTIONAL EDUCATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IEP <input type="checkbox"/> AIP | |
| HAS STUDENT EVER REPEATED A GRADE? <input type="checkbox"/> YES <input type="checkbox"/> NO WICH ONE? | | HAS STUDENT BEEN SUPENDED OR EXPELLED FROM ANY SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO | |

PARENTS/LEGAL GUARDIANS

| | | | |
|----------------------|------------------|---------------|-------------|
| LAST NAME: | FIRST NAME: | MIDDLE NAME | HOME PHONE: |
| PARENT SSN# | DRIVER LICENSE # | RELATIONSHIP: | CELL PHONE: |
| RESIDENCIAL ADDRESS: | | | |
| CITY | ZIP CODE | | |

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|-----------------------|---------|--------------------|-------------|
| PLACE OF EMPLOYEMENT: | | ADDRESS: | |
| CITY | ZIPCODE | OCCUPATION/ TITLE: | WORK PHONE: |

PARENTS/LEGAL GUARDIANS

| | | | |
|-----------------------|------------------|--------------------|-------------|
| LAST NAME: | FIRST NAME: | MIDDLE NAME | HOME PHONE: |
| PARENT SSN# | DRIVER LICENSE # | RELATIONSHIP: | CELL PHONE: |
| RESIDENCIAL ADDRESS: | | | |
| CITY | ZIP CODE | | |
| MAILING ADDRESS: | | | |
| CITY | ZIP CODE | E-MAIL ADDRESS | |
| PLACE OF EMPLOYEMENT: | ADDRESS: | | |
| CITY | ZIPCODE | OCCUPATION/ TITLE: | WORK PHONE: |

Parents, please make sure that all phone numbers, e-mail, and all contact information are kept current

ACADEMIC INFORMATION: LIST LAST THREE SCHOOLS ATTENDED:

| | | |
|----------------------|----------|--------|
| CURRENT SCHOOL NAME: | ADDRESS: | GRADE: |
| PREVIOUS SCHOOL: | ADDRESS: | GRADE: |
| PREVIOUS SCHOOL: | ADDRESS: | GRADE: |

ADDITIONAL INFORMATION:

| |
|----------------------------------|
| MEDICAL HISTORY |
| |
| ALLERGIES |
| |
| MEDICINE CURRENTLY TAKING |
| |

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EMERGENCY CONTACT and PICK UP:

FAMILY PERSONAL CODE:

| NAME | PHONE | RELATION SHIP |
|------|-------|---------------|
| | | |
| | | |
| | | |

ABA HEALTH SERVICES:

In the event of a serious accident or illness and I cannot be reached, I hereby authorized ABA to contact those professional to provide protected health information.

In case of emergency, I understand that ABA will access 911 emergency medical system immediately. To expedite care, I give my permission to ABA personnel to provide medical information to the responding emergency team to initiate treatment, and transport to an appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed above of my child's condition and admission. I agree to be financially responsible for my child's total treatment, and transport. Please initial by the service you are accepting.

I have received the above information and have made corrections as needed. Please initial.

Permission to: _____ Call Doctor _____ Call Ambulance _____ Treat

I certified that the information in this application is complete and accurate. I read the **ABA Health Services disclosure and understand it.** I understand that false statements within this application may result in delayed entry or withdrawal of admission.

ENCLOSED IS **MY NON-REFUNDABLE APPLICATION FEE: \$_____. **

Parent Signature

Date:

ABA maintains an open admission policy and does not discriminate based on race, gender, religion, national origin, or disability in its application process.