FELLOWSHIP CHRISTIAN ACADEMY

16355 Old Richmond Rd., Sugar Land, TX 77498
(281) 495-1814   (281) 495-1831 Fax

ADMISSION INFORMATION

Present Date _______________ Starting Date _______________ Class/Grade _______________ Date of Birth _______________

Child's Full Name ____ Male / Female
First Middle Last 'Nickname'

Child's Home Address ____ City and Zip ______________________________________

Child's Home Phone _______________________ Child Resides With ___Both Parents ___Mother ___Father ___Guardian

Mother's Name ____ Daytime Phone _______________________ Alternate Phone _______________________

Place of Employment ____________________________________ E-mail ____

Father's Name ____ Daytime Phone _______________________ Alternate Phone _______________________

Place of Employment ____________________________________ E-mail ____

Other than parents, *CHILD WILL BE RELEASED ONLY TO PERSONS INDICATED BELOW* (Must include at least TWO local persons to call for illness, accident, late pick-up, or other emergency reasons). *Please list them in the order of preference for us to contact.*

Name ____ Phone _________________________ Relationship _____________________

Name ____ Phone _________________________ Relationship _____________________

Name ____ Phone _________________________ Relationship _____________________

*******OR*******

No other person(s) has permission to pick up my/our child. ____
Signature of Parent/Guardian

Family Information

Names and ages of other children in the family ____

Has your child ever been in school before? ______ If yes, where ____

Church membership or religious preference ____

Multimedia Release

I give permission to Fellowship Christian Academy to photograph, videotape, and/or audiotape my child while participating in daily activities, and to use this media for educational, advertising, website, and social media purposes.

_____Yes _____No

____ ____

Signature of Parent/Guardian Date

School Year: 2017 - 2018

Child's Name ________________________________

Emergency Information

Consent to medical care and treatment of minor child

I, _____________________________________, hereby give permission that my child may be given emergency treatment, to include first aid and CPR by a qualified staff member of Fellowship Christian Academy. I further authorize and consent to medical, surgical and hospital care, treatment, and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health if I cannot be contacted. In such a case, I waive my right to informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I further authorize Fellowship Christian Academy to take my child to a hospital, and I agree that I will pay all physicians and hospital bills, and Fellowship Christian Academy shall not be responsible for them.

Medical Information

Does your child have any known allergies? _____Yes _____No

If yes, please specify allergies and any special attention required: ____

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Does your child have asthmatic problems? _____Yes _____No

If yes, please specify any special attention required: ____

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Does your child have any chronic medical conditions necessitating dietary supplements or restrictions, medication, or avoidance of allergens? _____Yes _____No

If yes, please specify any special attention required: ____

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Does your child require any restrictions on normal physical activities? _____Yes _____No

If yes, please specify any special attention required: ____

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____ ____

Signature of Parent/Guardian Date

School Year: 2017 - 2018