

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: 2018 - 2019

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: _____

Does your child have asthmatic problems? _____ Yes _____ No

If yes, please specify any special attention required: _____

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: _____

Does your child require any restrictions on normal physical activities? _____ Yes _____ No

If yes, please specify any special attention required: _____

Signature of Parent/Guardian

Date
School Year: 2018 - 2019