SONSHINE CHRISTIAN ACADEMY

STUDENT APPLICATION

FOR OFFICE USE ONLY

I.D. _____ APP. DATE _____
TEACHER _____ ENROLL. DATE _____
GRADE _____

Today's Date _____ Birthday _____ Name _____
(First) (Initial) (Last)
Social Security Number _____-_____-_____ Sex _____ Age _____ Grade to Enter _____

Address _____ Phone (_____) _____-_____

City, St. Zip _____ Last Grade Completed _____

School Last Attended _____ City, State _____

FAMILY INFORMATION

Father's Name _____ Cell Phone (____) _____ - _____

Employment _____ Position _____

Email: _____

Mother's Name _____ Cell Phone (____) _____ - _____

Employment _____ Position _____

Email: _____

Guardian's Name *(If different from above)* _____ CUSTODY RESTRICTIONS _____
(Please check and provide copy of court order)

Cell Phone (_____) _____ - _____ Email: _____

Employment _____ Position _____

List all children in family in order of birth:

Name (first and last)	Age	Sex	Living at home	School

Please check one of the following:

Van Rider☐ Car Rider☐ Walker☐ Other ☐

HEALTH INFORMATION

NOTE: THE PEOPLE LISTED ON THIS FORM MAY PICK UP YOUR CHILD

Parent's statement: I accept responsibility for notifying the school of any changes of home or business address or phone number. In the event of a serious illness or accident and I cannot be immediately contacted, I give my permission to my child to move by ambulance or other conveyance to a doctor's office or hospital for immediate attention. I also assume responsibilities for payments of the same. In case of an accident or illness where my immediate treatment is not needed, but where my child is unable to remain at school, I request the school contact me. If I am unable to be reached, I request that one of the persons listed below be contacted to care for my child until I can be reached.

Signature of Parent/Guardian: _____ Date: _____

Person(s) who will care for student in case parent can not be reached: **** MUST BE FILLED OUT ****

Name	Relationship	Cell Number
Name	Relationship	Cell Number
Name	Relationship	Cell Number
Name	Relationship	Cell Number

Please check if student has had problems with problems with the following:

Diabetes ☐ Severe allergies (list) ☐ _____ Asthma ☐
Kidney Disease ☐ Heart Disease ☐ Seizures (convulsions) ☐ Ears ☐ Speech ☐ Wears glasses ☐ Hearing aid ☐ Vision anything other than glasses ☐
Any other conditions that require observation: _____

Family Physician _____ Phone _____ Family Dentist _____ Phone _____

Please note any medications that student is currently taking:

_____