2020-2021 CCA Enrollment Form

Central Christian Academy

Student's Information

Student's Name: ______________________________
Last First Middle Suffix

Preferred Name: ____________ Title ____________ Grade Level: ____________

Date of Birth: ____________ Gender: ____________ SSN: ____________

Allergies ____________ Custody Issue ☐ Church Affiliation: ____________

E-Mail Address: ______________________________

Primary Family Information

Address Line 1: ______________________________

Address Line 2: ______________________________

____
City State ZIPCode County

Home Phone 1: ____________ ☐ Listed Phone 2: ____________ ☐ Listed

Father's Information

Father's Name: ______________________________
Last First Middle Suffix

Preferred Name: ____________ Title: ____________ Marital Status: ____________

Mobile Phone: ____________ Church: ____________ Home E-Mail ____________

Company Name: ____________ Job Title: ____________

Business Phone 1: ____________ Ext. ______ Emergency Contact: ☐ Tag ____________

Phone 2: ____________ Ext. ______ Allowed to pick up child: ☐ License ____________

Business E-Mail: ______________________________

Mother's Information

Mother's Name: ______________________________
Last First Middle Suffix

Preferred Name: ____________ Title: ____________ Marital Status: ____________

Mobile Phone: ____________ Church: ____________ Home E-Mail ____________

Company Name: ____________ Job Title: ____________

Business Phone 1: ____________ Ext. ______ Emergency Contact: ☐ Tag ____________

Phone 2: ____________ Ext. ______ Allowed to pick up child: ☐ License ____________

Business E-Mail: ______________________________

1) Emergency Contacts and Pickup Information

Emergency Contacts (Emergency Contacts other than Parents)

First Name: ______________________ Last Name ______________________

Home Phone: ________________

☐ Emergency Contact: Relation: ________________

Business Phone: ____________ Mobile Phone: ________________

☐ Allowed to pick up child:

DL#: ____________ Tag: ________________

Notes: ____

2) Emergency Contacts and Pickup Information

Emergency Contacts (Emergency Contacts other than Parents)

First Name: ______________________ Last Name ______________________

Home Phone: ________________

☐ Emergency Contact: Relation: ________________

Business Phone: ____________ Mobile Phone: ________________

☐ Allowed to pick up child:

DL#: ____________ Tag: ________________

Notes: ____

3) Emergency Contacts and Pickup Information

Emergency Contacts (Emergency Contacts other than Parents)

First Name: ______________________ Last Name ______________________

Home Phone: ________________

☐ Emergency Contact: Relation: ________________

Business Phone: ____________ Mobile Phone: ________________

☐ Allowed to pick up child:

DL#: ____________ Tag: ________________

Notes: ____

Medical Contacts

Physician: ________________ Phone Number: ________________

Dentist: ________________ Phone Number: ________________

Hospital: ________________ Phone Number: ________________

Insurance: ________________ Phone Number: ________________

Policy Number: ________________

Previous School Information

School Attended Last year: ____________________ Address: __________________________

Circle Grades Previously Attended At CCA: K4 K5 1 2 3 4 5 6 7 8

Check Primary Way Home: Carline ☐ After School Care: ☐

Medical Waiver

As parent/ legal guardian of _________________________, I do hereby authorize my consent to any X-ray, examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any licensed medical staff member under the provision of the Medical Practice Act. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority and power to render care which the aforementioned physician, in his or her best judgment, may deem advisable. It is understood that effort shall be made to contact me, the undersigned, prior to rendering treatment to my child, but that any of the above treatments will not be withheld if I cannot be reached. I agree to be responsible for paying any charges that may be incurred by such treatment. I hereby release Central Christian Academy of Martin, Tennessee, its staff, and representatives from any liability for accidents or injury sustained by my child in conjunction with any event.

Signature of Parent/Legal Guardian: __________________________ Date: ___________
Date of most recent Tetanus or DPT immunization: _____________
Is this child on any medication? Yes No
If so what? ____
Does this child have any allergies? Yes No
Please list allergies and
reactions:____

____
Please list any other medical information or physical problems:
____
____
____

Additional Pickup List

The following people have permission to drop off/pick up my child in the event that I cannot.

Name Relationship Phone number

1.____

2.____

3.____

Parent/Legal Guardian Signature: ___________________ Date: ___________

CCA "At Risk" Policy

CCA will NOT release my child to someone who appears to be incapacitated or aggressive for any reason. If a "pick-up" person is suspected of this behavior, CCA staff will notify me to pick up my child to ensure their safety. If I, the parent, is the one showing signs of diminished capacity, a person on my child's pick-up list will be contacted to pick up my child. I understand that if I insist on taking my child with me while in this state of duress, the police will be called to intercept and arrest me for endangering my child. CCA is seeking to provide the safest environment for my child and I agree to abide by this policy statement.

Parent/ Legal Guardian Signature: _________________ Date: _________________

CCA Photograph Release

I hereby grant permission to CCA to take photographs of my child while practicing in school activities. I understand that these photos may appear in forms such as, display panels, teacher-made books, DVDs, CCA website, Facebook and other forms of advertisement used to market CCA. I also understand that I am to receive no compensation for my child's appearance. I also understand that my child's participation confers on me no ownership rights to the photographs or negatives whatsoever.

Parent/ Legal Guardian Signature: _________________ Date: _________________

CCA Anaphylaxis Treatment Plan

Student Name: ____________________ Date of Birth: _________________________

Has the student had an Anaphylactic reaction? Yes ☐ No☐

What is the child allergic to? Dairy☐ Peanuts☐ Tree Nuts☐
Eggs ☐ Soy ☐ Wasp Stings☐
Fish☐ Shellfish☐ Bee Stings☐

Other: ____

Has the student been educated on signs and symptoms of anaphylactic reaction and able to notify adult if experiences these symptoms? Yes☐ No☐

If exposed to allergen do you administer Benadryl before using EpiPen/EpiPen Jr?
Yes☐ No☐

School Policy: All school nurses will use epi-pen trainer and teach school staff, who are willing to administer the Epi-Pen, in the event a child has a severe allergic reaction. All teachers or staff that are trained will sign the Epi-Pen in-service form. The form will be kept in the school nurse office. If a student has an Epi-Pen for allergies to bee or wasp stings, the Epo-Pen needs to go out on the playground with the teacher of staff member who will administer the device. If a student goes on a field trip the Epi-Pen must accompany the student in the medications bag. Also, it should be noted in the substitute folder that a student in the class has severe allergies and the location of the Epi-Pen should be documented.

Choose student dose: EpiPen Jr. 0.15mg☐ EpiPen 0.30mg☐

Upon administration, 911 will be called (along with parent) and transported to nearest Emergency department. A second dose of EpiPen/EpiPen Jr may be given, if available, if EMS has not arrived or symptoms of anaphylaxis has not abated after 15 minutes.

Do you agree with the above treatment plan? Yes☐ No☐

If you answered no, please make modifications to this protocol regarding the indications and mode of treatment. Please specify medications ordered, the administration, and disposition of child in detail. Please use a separate sheet of paper if necessary. (NOTE: If requesting Benadryl please state dose and if to be given before or after EpiPen/EpiPen Jr injection.)

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____
____
____
___

Parent/Legal Guardian Signature: _____________________ Date: ________________

Phone: _________________ Alternate Phone: _______________________

Primary Care Physician: _______________________ Phone: ____________________

Teacher: _____________________ Grade: ________

Authorization for Administration of Non-Prescription Medicine

This request is to be effective for the school year _______or earlier stop date: ______

Students name: _____________________________Date of Birth: ________________

Medication____

Generic Name (If Used): ____

Dosage Amount: ___________________________ Please administer, according to manufacturer's label for recommended time schedule, when needed at school for the following conditions or symptoms:

____

____

I request the designated school personnel to assist my child in the administration of the above described medication. I give permission for my child to take this medication at school. I understand that: (1) there is no liability on the part of Central Christian Academy, its personnel, or agents for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication should be brought to the school only by a responsible person; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first.

Parent/Legal Guardian Signature: ____________________ Date: _______________
Address: _______________________________ Home Phone: _________________
Work Phone: ________________

Non- prescription medication requests must be renewed by the parent/guardian and a release signed by the parent/guardian annually, each medication, or any change in medication, requires a new form. The parent/ guardian will be responsible for ensuring that medicines provided for the school have not expired.