Columbus Christian Academy

"Educational Excellence for Christ"

Date Application Completed _____ Date of Enrollment _____

CCA Preschool Student Application

Child Information

Name_____ _____
(Last) (First) (Middle) (Nickname)
Male/Female_____Age (as of 8/31/17) _____ Date of Birth_____ Phone_____
Child's Physical Address_____
Child's Mailing Address_____

Family Information

Father/Guardian's Name_____ Phone_____
Email_____
Address (if different from child's) _____ Zip _____
Work Phone_____ Cell Phone _____Home Phone _____
Mother/Guardian's Name_____ Phone_____
Email_____
Address (if different from child's) _____ Zip _____
Work Phone_____ Cell Phone _____ Home Phone_____
Marital Status: Married___ Widowed___ Divorced___ Separated___ Single___
Student Lives With?_____
Who Has Legal Custody?_____ **Provide Legal Custodial
Does Other Parent Have Visitation Rights?_____ Documents**

Religious Information

Church Attended_____Denomination_____
Other Background Information: _____
Father - Christian?___Yes ___No Mother - Christian? ___Yes ___No

How did you learn of CCA?_____
Why did you choose this school? _____
Are your other children attending? _____

Scholastic Information

Which of the program options will suit your needs?

Student Age	Times to Attend (circle all that apply)	Days Per Week
(As of Aug 31, 2017)	Morning Only	2(Tues, Thur)
3	Full Day	3(Mon, Wed, Fri)
4	Extended Care: Morning	5(Mon - Fri)
5	Afternoon	

Name_____
(Last) (First) (Middle) (Nickname)

Health Care Needs

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional.

Is there a medical action plan attached? No___ Yes___

List any allergies and the symptoms and type of response required for allergic reactions. _____

_____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns

_____

List any particular fears or unique behavior characteristics the child has _____

_____

List any chronic illness the individual has and any medication taken for that illness _____

_____

Share any other information that has a direct bearing on assuring safe medical treatment for your child _____

_____

Has applicant received all the required immunizations?_____ (Record of current immunizations or waiver required for attendance)

Please give any information concerning your child which will be helpful in his experience in group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes).

_____

_____

EMERGENCY CARE INFORMATION:

Name of Healthcare Professional _____Phone _____

Hospital preference _____Phone _____

Parent OR other person to be called in case of emergency (please list relationship):

Name _____ Address_____ Phone _____

Name _____ Address _____ Phone _____

Name _____ Address_____ Phone _____

Name _____ Address_____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

_____ _____

(Signature of Parent/Guardian (Date)

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

_____ _____

(Signature of Operator) (Date)

I have read all the informational materials provided and agree to abide by the academic and disciplinary policies and regulations of the school; and to require that my child give full cooperation to the specifics and spirit of those regulations.

Mother's Signature _____ Date_____

Father's Signature _____ Date_____