Student Application for Admission

Please complete <u>one of these forms for each student</u> you are enrolling

Student's Legal Name _____ Date of Birth _____

Goes by _____ Age _____ Gender _____

Student's Cell Phone _____ Student's Email _____

Father's Name _____ Mother's Name _____

<u>Academic Information</u>

1. Grade to enter _____ at LCS for school year _____
2. Last school student attended: _____

   Last school's office contact (*if known*):_____

☐ *I authorize LCS to reach out to student's previous school for the release of school records upon acceptance of this application.*

(*parent initial*) _____

☐ If possible, include a transcript of the student's previous school work, or copies of their current report card in order that we can make an accurate placement. (*In many cases we will ask that your student completes a placement test in some subjects prior to grade placement.*)

3. Has student ever repeated a grade? _____ If yes, which grade? _____
4. Does the student have a learning disability or limitation which may require special professional assistance?_____

   If yes, please explain: _____

   _____

   _____
5. Has student ever been ejected, suspended, or moved from a school? _____ If yes, please give the school name, date, and cause of action: _____

   _____

   _____
6. Has the student ever been under the supervision of a parole officer, or under the jurisdiction of a juvenile court? _____

   If yes, on a separate piece of paper give the full name and address of the judge or probation officer involved.

For Students as appropriate…

1. Has student made a confession of faith?_____
2. Is student a church member? _____ If yes, where?_____
3. How often does student attend church? Weekly _____ Monthly _____

Medical Release Form

Please complete <u>one of these forms for each student</u> you are enrolling

Student Name _____ Date of Birth _____

<u>Immunization Records</u> *Please choose one of the following options:*

☐ I have included a copy of our child's immunization records to keep on file.

☐ Our child does not have immunization records, due to an exemption of good cause, and <u>I have completed the attached exemption document.</u>

<u>Allergies/Intolerances</u> *Please list all your student's allergies to medications, insects, food, etc.*

_____ (EpiPen? Y N)

<u>Health Action Plan</u>

Please circle **(*Yes or No*)** My child has a known medical condition which requires prescribed medication, major restrictions, and/or additional training for the staff in case of emergency.
If yes, briefly describe the condition _____
By circling yes above, I am asking the office to send me a copy of a Health Action Plan form to complete and keep on record.

<u>Over-the-Counter Medications</u>
As a parent/guardian of a student in Legacy Christian School, I realize that I will not always be available in times of medical needs. Therefore, I am authorizing the school staff to administer the following medications when they deem best for the health and well-being of my child. I understand that any of the below listed procedures I do not initial will not be carried out by the staff without my permission.
The following over-the-counter medications will be available to your student. All OTC medication dosages will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. (Generic substitutions may be used for listed medications.)

Please INITIAL next to the medication(s) you give permission to be administered to your student.

_____ Tylenol/Acetaminophen
_____ Advil/Ibuprofen
_____ Benadryl/Antihistamine
_____ Sudafed/Decongestant
_____ Tums/Antacids
_____ Pepto-Bismol/Immodium
_____ Robitussin/Cough Medicine/Cough Suppressant
_____ Cough Drops
_____ Dramamine/Bonine/motion sickness prevention
_____ Vitamin C (250g gummies)

If I am not available by phone, I give the staff permission to call emergency personnel to take my child to the hospital to do whatever medical procedures are deemed best by the medical staff. (*parent initial*) _____

If my child must go to the hospital, I prefer my child be taken to:

_____ Union Hospital, Dover, Ohio
_____ Joel Pomerene, Millersburg, Ohio
_____ Other _____

Family Doctor _____ Phone _____

I have read and agree with the above statements.

Parent/Guardian Signature _____ Date _____

State Of Ohio Legal Immunization Exemption Form

Per OHIO STATUTE 3313.671 (EXEMPTIONS)

Only to be completed if your child does not have immunization records.

Student Name: _____

School: _____

Legal Parent/Guardian:_____

Please INITIAL

I hereby withdraw my consent to have my child immunized against the following:

_____TDaP (Diphtheria, Pertussis, Tetanus)

_____Meningitis

_____MMR (Measles, Mumps, Rubella)

_____Hepatitis B

_____Polio

_____Varicella (Chicken Pox)

This request is in accordance with the OHIO PURVIEW for EXEMPTION of GOOD CAUSE, INCLUDING RELIGIOUS CONVICTIONS, MEDICAL REASONS, or REASON OF CONSCIENCE.

Please Select One:

☐ **Religious Reason** – Please Name your Denomination: _____

☐ **Medical Reason** – Please include a signed statement from your physician stating the condition.

☐ **Reason of Conscience** – Please explain: _____

_____

_____

I further understand that during the course of an outbreak of any of the vaccine preventable diseases mentioned above that the student named here is subject to exclusion from school for the duration of the outbreak. This action is necessary not only to protect this student, but the remainder of the students and faculty of the school.

(*parent initial*) _____

TO BE FILED AS LEGAL PROOF OF OUR OBJECTION WITH OUR CHILD'S SCHOOL HEALTH RECORD.

Parent/Guardian Signature _____ Date _____