LIVING FAITH ACADEMY

2022-2023 Application for Admission

Today's Date _____

STUDENT INFORMATION

Student Name _____ _____ _____

Last First Middle

Home Address _____

Street

_____ _____ _____

City State Zip Code

Mailing Address (If different from above)

_____

Home Telephone # ( ) _____ Cellphone # ( ) _____

Student's Age _____ Birthdate _____ Social Security # _____

Gender: Male____ Female _____ Ethnicity _____ Grade_____

HAS YOUR CHILD EVER BEEN ENROLLED IN A SPECIAL EDUCATION CLASS (check all that apply)?

( ) SPEECH ( ) LD ( ) ESOL ( ) GIFTED ( ) 504 ( ) OTHER

DOES YOUR CHILD HAVE AN IEP?

( ) Yes ( ) No

PARENT INFORMATION—PLEASE UPDATE ALL CONTACTS:

Mother/Step-mother/Guardian Information	Father/Step-father/Guardian Information
Name _____	Name _____
Employer _____	Employer _____
Work Phone # _____	Work Phone # _____
Cellphone # _____	Cellphone # _____
Occupation _____	Occupation _____
E-mail Address _____	E-mail Address _____

If parents are divorced or separated, with whom does the student live? (Include address if different from above.)

_____

Child's Physician _____ Telephone # _____

Physical Defects or Allergies? _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, sex, age, or disability.

Church currently attending _____

Pastor _____ Member? ☐ Yes ☐ No

School last attended (Name, Address, Tel #) _____

_____

EMERGENCY CONTACT PERSON

1. Name _____ Relationship _____ Phone # _____
2. Name _____ Relationship _____ Phone # _____
3. Name _____ Relationship _____ Phone # _____
4. Name _____ Relationship _____ Phone # _____

PERSON, OTHER THAN PARENTS, ALLOWED TO PICK UP STUDENT

(anyone else will need written permission from the parents and a photo I.D.).

1. Name _____ Relationship _____ Phone # _____
2. Name _____ Relationship _____ Phone # _____
3. Name _____ Relationship _____ Phone # _____
4. Name _____ Relationship _____ Phone # _____

Additional Notes or Comments:

_____

_____

FLA. STATUTE 837.06—WHOEVER KNOWINGLY MAKES A FALSE STATEMENT IN WRITING WITH THE INTENT TO MISLEAD A PUBLIC SERVANT IN THE PERFORMANCE OF HIS OFFICIAL DUTY SHALL BE GUILTY OF A MISDEMEANOR OF THE SECOND DEGREE, PUNISHABLE AS PROVIDED IN S.775.082 OR S.775.083.

THE INFORMATION GIVEN BY ME ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE (Mother)	DATE
SIGNATURE (Father)	**DATE**
SIGNATURE (Legal Guardian)	**DATE**

Office Use Only

Fee Paid $ _____ Date _____ _____Cash _____ CC Billed _____

_____MO _____ CK # _____ Approve: Y__ N__

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IS YOUR CHILD COVERED BY MEDICAID? ( ) Yes, Child has Medicaid ( ) No

DOES YOUR CHILD HAVE INSURANCE OTHER THAN MEDICAID? (Please check one):

( ) Child has Health Care Insurance ( ) Child does not have Health Care Insurance/Medicaid

( ) Child has Healthy Kids Insurance

IS YOUR CHILD IMMUNIZATION UP-TO-DATE? (Copy is needed)

( ) Yes ( ) No

DOES YOUR CHILD HAVE A LIFE THREATING CONDITION? ( ) Yes ( ) No

IF YES, PLEASE INDICATE WHETHER THE CONDITION REQUIRES ANY OF THE FOLLOWING (Med. Alert Req) (**Please check all that apply):**

( ) Asthma Inhaler ( ) Diastat ( ) Epi-Pen ( ) Insulin Injection

Health Conditions: Please check all that apply. Indicate the date of diagnosis (if Known), and whether medication is required.

	Conditions	Date Diagnosed	Med Req?		Conditions	Date Diagnosed	Med Req?
( )	Allergy-Aspirin	___/__/___	( )	( )	Hemia	___/__/___	( )
( )	Allergy-Insect Bites	___/__/___	( )	( )	Heart Disease	___/__/___	( )
( )	Allergy-Iodine	___/__/___	( )	( )	Hypertension	___/__/___	( )
( )	Allergy-Penicillin	___/__/___	( )	( )	Kidney Disease	___/__/___	( )
( )	Allergy-Sulfa	___/__/___	( )	( )	Leukemia	___/__/___	( )
( )	Allergy-Other	___/__/___	( )	( )	Medical Alert	___/__/___	( )
( )	Anemia	___/__/___	( )	( )	Muscular Dystro-phy	___/__/___	( )
( )	Anaphylactic Reaction	___/__/___	( )	( )	Motor Impair-ment	___/__/___	( )
( )	Asthma	___/__/___	( )	( )	Multiple Health Problems	___/__/___	( )
( )	Attention Deficit Hyperactivity Disorder	___/__/___	( )	( )	Physical Develop-ment	___/__/___	( )
( )	Cerebral Palsy	___/__/___	( )	( )	Physical Impair-ment	___/__/___	( )
( )	Diabetes	___/__/___	( )	( )	Pregnancy	___/__/___	( )
( )	Ear Infection-Repeated	___/__/___	( )	( )	See School Rec-ords	___/__/___	( )
( )	Pen Injection	___/__/___	( )	( )	Rh. Negative Blood	___/__/___	( )
( )	Epilepsy	___/__/___	( )	( )	Scoliosis	___/__/___	( )
( )	Gastro Intestinal Condition	___/__/___	( )	( )	Seizure Disorder	___/__/___	( )
( )	Hearing Impari-ment	___/__/___	( )	( )	Sickle Cell	___/__/___	( )
( )	Hypoglycemia	___/__/___	( )	( )	Speech Impair-ment	___/__/___	( )
( )	Hemophilia	___/__/___	( )	( )	Urological Condi-tion	___/__/___	( )
( )	Visual Impair-ment	___/__/___	( )	( )	None of the above	___/__/___	( )