LIVING FAITH ACADEMY

2024-2025 Application for Admission

Today's Date _____

STUDENT INFORMATION

Student Name _____ _____ _____

Last First Middle Initial

Home Address _____

Street

_____ _____ _____

City State Zip Code

Mailing Address (If different from above)

_____

Student's Age _____ Birthdate _____ Social Security # _____

Birth Gender: ( ) Male ( ) Female Ethnicity _____ Current Grade_____

⇒ Has your child ever been enrolled in a special education class (check all that apply)?
( ) SPEECH ( ) LD ( ) ESOL ( ) GIFTED ( ) 504 ( ) OTHER

⇒ Is your child covered by Medicaid?
( ) Yes, Child has Medicaid ( ) No

⇒ Does your child have insurance other than Medicaid (check one)?
( ) Child has Health Care Insurance ( ) Child does not have Health Care Insurance/Medicaid ( ) Child has Healthy Kids Insurance

⇒ Is your child's immunization up-to-date? (A copy of immunization 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: (check all that apply)
( ) Asthma Inhaler ( ) Diastat ( ) Epi-Pen ( ) Insulin Injection

Child's Physician _____ Telephone # _____

Physical Defects or Allergies? _____

Any brothers and/or sisters that also attend/will be attending Living Faith Academy? (Please list below)
( ) My child has no sibling(s) that attend/will be attending Living Faith Academy

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

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.

PARENT INFORMATION

( ) **Mother** ( ) **Step-Mother** ( ) **Legal Guardian (Check one)**

Name _____ Address _____

Employed by _____ Occupation _____

Cellphone _____ Work Phone _____

Email Address _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

( ) **Father** ( ) **Step-Father** ( ) **Legal Guardian (Check One)**

Name _____ Address _____

Employed by _____ Occupation _____

Cellphone _____ Work Phone _____

Email Address _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

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

_____

EMERGENY CONTACT & PICK-UP INFORMATION

EMERGENCY CONTACT PERSON

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

List names of persons authorized to take child from school. Child **WILL NOT** be allowed to leave with any other person without **WRITTEN** authorization and a photo I.D.

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

Church currently attending _____

Pastor _____ Member? ( ) Yes ( ) No

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

_____

ADDITIONAL STUDENT HEALTH INFORMATION

Student's 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 Dystrophy	___/__/___	( )
( ) Anaphylactic Reaction	___/__/___	( )	( ) Motor Impairment	___/__/___	( )
( ) Asthma	___/__/___	( )	( ) Multiple Health Problems	___/__/___	( )
( ) Attention Deficit Hyperactivity Disorder	___/__/___	( )	( ) Physical Development	___/__/___	( )
( ) Cerebral Palsy	___/__/___	( )	( ) Physical Impairment	___/__/___	( )
( ) Diabetes	___/__/___	( )	( ) Pregnancy	___/__/___	( )
( ) Ear Infection-Repeated	___/__/___	( )	( ) See School Records	___/__/___	( )
( ) Pen Injection	___/__/___	( )	( ) Rh. Negative Blood	___/__/___	( )
( ) Epilepsy	___/__/___	( )	( ) Scoliosis	___/__/___	( )
( ) Gastro Intestinal Condition	___/__/___	( )	( ) Seizure Disorder	___/__/___	( )
( ) Hearing Impariment	___/__/___	( )	( ) Sickle Cell	___/__/___	( )
( ) Hypoglycemia	___/__/___	( )	( ) Speech Impairment	___/__/___	( )
( ) Hemophilia	___/__/___	( )	( ) Urological Condition	___/__/___	( )
( ) Visual Impairment	___/__/___	( )	( ) None of the above		

Any additional helpful information about your child: ( ) Yes—if Yes, comment below ( ) No

_____

_____

_____

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/Step-mother)	**DATE**
SIGNATURE (Father/Step-father)	**DATE**
SIGNATURE (Legal Guardian)	**DATE**

Office Use Only

Fee Paid $ _____ Date _____ _____Cash _____ CC Billed _____

_____MO _____ CK # _____ Approve: Y__ N__

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