

Endtime Christian School of Excellence
555 Burns Avenue
Lake Wales, FL 33853
(Phone) 863-589-5283 (Fax) 863-949-6125



APPLICATION FOR ENROLLMENT

Endtime Christian School and Church admits students of any race, color national origin or Ethnic origin.

Name _____ Boy _____ Girl _____ Race _____

Address _____ Phone _____

_____ SS# _____

Date of Birth _____ Place of Birth _____

Where does your child attend church? _____

Where did your child last attend school? _____

PARENT GUARDIAN INFORMATION

MOTHER

FATHER

Name _____

Address _____

Address _____

Employer _____

Employer _____

Occupation _____

Occupation _____

Work # _____

Work# _____

Cell# _____

Cell# _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Other _____

Applicant's primary residence is with Both Parents _____ Mother _____ Father _____ Other _____ Guardian _____

If you have indicated "Other" or Guardian, please state your name and relationship to the students. _____

Please fill out the following as they pertain to the applicant (Special/Exceptional programs means such areas as tutoring, gifted, speech, emotional, etc.).

Has the applicant even been referred, screened, or recommended for or enrolled into special exceptional program(s)? If Yes, please explain. Yes _____ No _____

In your view, what are the applicant's educational strengths? _____

In your view, what are the applicant's educational areas that need improving? _____

Please list any other items concerning the applicants of which the school should be aware: (e.g. specific needs, emotional needs, allergies, or medication he/she is taking) _____

Please give the primary reason for seeking enrollment in Endtime Christian School of Excellence for your child.

Please tell us how you heard about ECSE: _____

The information that was given on this form is completed and accurate to the best of my knowledge.

Parent/Guardian Signature

Date

Student Image and Technology OPT-OUT Section

The school and church have permission to use photographs that includes students in promotional brochures and other school publications such as media, website, television, videos, honors, awards, accomplishments, and announcements etc. unless parent's request below to the refusal that pictures of their child not be used.

Please place a check in the blank provided for each of the following of which you do **NOT** want your child to participate and sign at the end of this document.

1. _____ My child **does not have** permission to access the school/district network computers, which include the internet, newsletters, yearbooks, photos, or videos etc.

2. _____ My child **does have** my permission to access the school/district network computers which include the internet, newsletters, yearbooks, photos, or videos etc.

By signing this Student Image and Technology OPT-OUT Section, I agree to the above conditions:

ENDTIME CHRISTIAN SCHOOL OF EXCELLENCE MEDICAL INFORMATION FORM

I understand that it is my responsibility to notify the school of any changes in the information recorded on this form.

Teacher _____

Grade _____

Student _____ Boy Girl
First Middle Last

Birthdate _____ Home Phone# _____ Student ID # _____

Address _____

Mailing Address _____

Parent Name	Home Phone	Work Phone	Cell Phone	Lives With?	Ok to Pickup?
				Yes__ No__	Yes__ No__
				Yes__ No__	Yes__ No__
				Yes__ No__	Yes__ No__

Please circle any and all conditions that apply to your child. I understand and agree that certain educational records of my child may be shared with any other school health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment and records.

- | | | |
|------------------------------|-----------------------------------|-----------------------------|
| 1. Asthma/breathing problems | 7. Cancer | 13. Hearth Problems |
| 2. ADD/ADHD | 8. Cystic fibrosis | 14. Kidney problems |
| 3. Bladder problems | 9. Dental (tooth) problems/braces | 15. Mental health problems |
| 4. Bleeding problems | 10. Diabetes | 16. Nosebleeds (frequently) |
| 5. Bone/joint problems | 11. Epilepsy/ seizures. | 17. Sickle Cell Disease |
| 6. Bowel problems | 12. Headaches (severe) | |

Please explain any circled items or other serious surgeries, illnesses or injuries: _____

In your opinion, might any of the problems circled above, or any other medical condition your child has affect his/her school performance, program or ability to participate in a regular physical education program? If yes, explain: _____

	None	Mild	Moderate	Severe (needs meds)	Life Threatening (Call 911)
Insect bites/ stings					
Food/ plants/ other					
Medicines					

Please list any allergies and reactions and check the appropriate column stating the severity of each:

If your child has asthma, has it been diagnosed by a doctor? Yes___No___. If yes, what treatment has been prescribed? _____ Inhaler _____ Nebulizer _____ Other, Please list: _____

Will your child be taking any medications at school, either prescription or over-the-counter? Yes___No___
If yes, please list: _____

If yes, parent must provide a new Authorization for Medication form each school year. All medications must be brought to school by an adult.

Doctor's Name _____ Phone# _____
Date of Last physical _____

Dentist Name _____ Phone# _____

Health Insurance Yes___No___ Name of insurance: _____

Medicaid Yes___No___ Medicaid # _____ If yes, Endtime
Christian School of Excellence Private School has my permission to bill Medicaid for any eligible therapeutic services provided for my child school. Yes___No___

****Please provide the information below for the responsible adults to contact if parents cannot be reached****

Name	Home Phone	Work Phone	Cell Phone Or Beeper	Relationship
1.				
2.				
3.				
4.				

PARENTAL CONSENT

School _____ Grade _____

Student's Full Name _____ Date of Birth _____

I am aware that in order for my child to receive any medication at school, I must provide a new Authorization for Medication signed by myself and my child's doctor each school year. All medications must be brought to school by an adult.

In case of serious accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed above. In the event the adults listed above cannot be reached the school makes whatever arrangement are necessary to provide care and treatment for my child. When necessary, and in the event that I or any adult listed above cannot be reached, school personnel have my permission to release the information on this form to emergency personnel. I understand and agree that I will be responsible for any emergency medical services fees.

In case of accident or illness where, the best judgement of school personnel, emergency treatment of my child is not needed, but where he/she is unable to remain at school, I request the school to contact me to arrange transportation for my child. If the school is unable to contact me, I understand that one of the above listed adults to be contacted and requested to arrange transportation/care for my child until I can be reached.

I certify that the information I have provided on this Medical Information Form is accurate, true and correct.

Date: _____ Parent/Guardian Signature _____

ENDTIME CHRISTIAN SCHOOL OF EXCELLENCE
PHYSICAL EDUCATION PARTICIPATION FORM



Name _____ Grade _____

The following information is required regarding the physical condition each year by his/her physical education program.

Physical Condition of the Student:

It is recommended that a student be given a physical examination each year by his/her physician. As a result of the most recent examination.

____My child is physically able to participate in the physical education program at Endtime Christian School of Excellence.

____My child is NOT physical able to participate in the physical educational program at Endtime Christian School of Excellence.

Date: _____

Parent Signature: _____

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In the event that your child is NOT able to take part in the regular physical education program the following form needs to be completed by your physician.

List activities recommended

Specific directions for instructor

It is recommended that this student participate during the period beginning (date) _____ and ending (date) _____ only in the activity or activities listed above.

Parent's Signature: _____

Endtime Christian School of Excellence

Student Data Sheet

Basic Student Information

Name: _____

Home Address:

Street: _____ City, State _____

P. O. Box: _____ City, State _____

Home Phone/Cell _____

Grade: _____ Sex: _____ Please check one: ()Black ()White ()Hispanic ()Multicultural Black
()Multiracial Non-Black ()Asian ()Indian

Language of Student: _____ Language of Parents: _____

Date of Birth: _____ Place of Birth: _____
City County State

Name/Address of Previous School _____ Has the student ever been enrolled in a Polk County School Y or N
_____ Has the student ever been retained? Y or N What grade? _____
_____ Is the student enrolled in an ESE Program? Y or N

Phone # _____

County _____

Family Information: Student lives with () Both Parents () Mother () Father () Stepparents () Guardian

Father

Mother

Guardian

Name: _____ Name: _____ Name: _____

Work: # _____ Work: # _____ Work: # _____

Home: # _____ Home # _____ Home: # _____

Cell # _____ Cell # _____ Cell: # _____

Siblings at home or that attend school (please note the school they attend):

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Emergency Contact Information if parents are unavailable:

Primary Contact:

Secondary Contact:

Name: _____ Name: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

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(For Office Use Only)

Teacher _____ Grade: _____ Date: _____ Affidavit: _____