

EAST BAY CHRISTIAN SCHOOL

2019-2020 REGISTRATION FORM

(Please Print)

STUDENT INFORMATION						
Student's First Name		Middle:	Last:		Suffix:	Preferred Name:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity:	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date: / /	Age:	SSN:	Grade Entering:
Child's Address:		City:		State:	ZIP Code:	

PARENT / GUARDIAN INFORMATION						
Father's Name:		Custodial Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Address (if different than child's):			
Father's Home Phone:	Cell:	Work:	Ext.	Email:		
Father's Employer:	Lives with Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receives Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receives Bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother's Name:		Custodial Parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mother's Address (if different than child's):			
Mother's Home Phone:	Cell:	Work:	Ext.	Email:		
Mother's Employer:	Lives with Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receives Mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receives Bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY INFORMATION				
Student lives with: (Please check all that apply.) <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepfather <input type="checkbox"/> Stepmother <input type="checkbox"/> Other:			Parent's Divorced? <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal Custody with?
Do you have a church home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Church:	Active Members? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you attend? <input type="checkbox"/> Regularly <input type="checkbox"/> Seldom <input type="checkbox"/> Never	

ALTERNATE NUTRITION PLAN AGREEMENT						
I understand and approve the use of the Alternate Nutrition Plan. I agree to provide the following meals and/or snacks to meet my child's nutritional and dietary needs. Indicate special Dietary Requirements:						
(Mark P for Parent Provides or S for School Provides)						
Breakfast: P	A.M. Snack: P	Noon Meal: P	P.M. Snack: P	Dinner Snack: P	Evening: P	Formula: N/A
The parent's or legal guardian's signature below certifies agreement and compliance with the alternative nutrition plan outlined above.						
Signature of Parent or Legal Guardian:				Date:		

Office Use Only:	<input type="checkbox"/> Physical	<input type="checkbox"/> Immunization	<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Testing	<input type="checkbox"/> Shirts	<input type="checkbox"/> CPU Rec	<input type="checkbox"/> Records Req.
<input type="checkbox"/> Step Up / AAA	<input type="checkbox"/> Reg Fee	<input type="checkbox"/> Book Fee	<input type="checkbox"/> Check: #	<input type="checkbox"/> Cash: Receipt #	<input type="checkbox"/> Mon. Order #		

PREVIOUS SCHOOL INFORMATION

(For New Student Enrollments ONLY)

How did you hear about EBCS?	Referred by:	Is this the first time the applicant has attended any school or homeschool? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last School Attended:	Last School Address:	Last School Phone:
Reason for leaving last school:	Principal at last school:	Teacher(s) at last school:
Do you have a copy of the applicant's last report card and/or transcript?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant ever been suspended?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant ever been expelled?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant ever had any encounters with law enforcement or juvenile authorities?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant received testing/counseling by a psychologist, psychiatrist, or family counselor?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant ever been diagnosed or in a program for a learning disability?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant ever been in an IEP (Individualized Education Plan) with or without ARD (Admission, Review, Dismissal)?		<input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER INFORMATION

(To be completed for ALL applicants)

Please understand that the office staff communicates with parents using a variety of methods.
We will do our best to communicate in a way that is also convenient for you.

Preferred Method of Communication from the Office:

Letters/Memos Phone Email Text In person (car line, etc.)

As evidenced by my/our signatures as the Parent(s) / Guardian(s), I/we acknowledge that I/we have read, understood, and agree to the following conditions for enrollment of the above-named applicant. (Please initial each statement and sign the bottom.)

- _____ I understand that all Registration Fees are non-refundable.
- _____ I acknowledge that my child's Book Fees must be paid in full before my child may attend classes at EBCS.
- _____ Three tuition payment options are available, from which parents select at the time of registration each year. (Please select one below.)
- One payment Two payments Ten monthly payments
- (Yearly tuition paid in full) (Yearly tuition paid in two payments) (beg. Aug. 1st)
- _____ I understand that in the case of my child being withdrawn from school for any reason, I am responsible for the entire tuition of the payment period in which the student was withdrawn.
- _____ I understand that returned check fees and late payment fees may be added to my account if necessary.
- _____ I acknowledge that if my child uses the Extended Care services, I will pay the incurred charges for those fees along with my regular tuition payment each month. If a child is not picked up on time, late fees will be added to my account. (Please indicate your intention for using Extended Care services below.)
- Daily (\$150/month/student) Occasionally (\$10/day/student) Never
- _____ **Step Up/AAA Students Only:** I realize that Step Up/AAA funds do not cover the cost of Extended Care. If my child uses the Extended Care program or incurs other fees not covered with the scholarship program, I will be responsible to pay the charges that are incurred.
- _____ I realize that I must submit a current copy of my child's Florida Physical form, Florida Immunization Record, and Birth Certificate before my child will be able to attend classes at EBCS.
- _____ I give permission for pictures taken of my child at EBCS or EBCS school functions to be used in the school yearbook and/or on the website/promotions.
- _____ I have received a copy of the current dress code information and realize that changes may be made to this dress code when I receive the new handbook. I will read the dress code again upon reception of the new handbook.

Father's Signature: _____ Mother's Signature: _____

Date: _____ Date: _____

EAST BAY CHRISTIAN SCHOOL

2019-2020 MEDICAL AND EMERGENCY INFORMATION

STUDENT INFORMATION				
Student's First Name:	Middle:	Last:	Suffix:	Birth Date: / /
Child's Address:		City:	State:	ZIP Code:
Child's Physician:	Physician's Phone #:	Physician's Address:		Preferred Hospital:
Child's Allergies:	Current on immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No		Religious or Medical Exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child regularly take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No		History of Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Wear contact lenses or glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of last tetanus:
Additional Health Problems:				

PARENT/GUARDIAN INFORMATION				
Father's Name:	Emergency Phone #:	Employment:	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's Name:	Emergency Phone #:	Employment:	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No
In case of emergency, who should be contacted first? <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other:				
Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder's Name:	Insurance Company:	Policy Number:	Insurance Company Address:

EMERGENCY CONTACTS				
If a need arises for my child to be picked up from school and I cannot be reached, I authorize school personnel to call any of the following persons to pick up my child. (Please list emergency contacts in the order you would like them to be contacted.)				
Contact Name:	Relationship:	Phone:	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT		
<p>If my child (full name), _____, should become ill or injured at East Bay Christian School (EBCS), I understand that the school will: (1) Attempt to contact me immediately and/or (2) Contact the person(s) I have designated if I cannot be reached.</p> <p>Should EBCS be unable to reach me and/or the person(s) designated, if the nature of the illness is time sensitive and first requires immediate summoning of medical personnel, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.</p> <p>The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.</p> <p>I will accept full responsibility for payment of Emergency transportation and Medical Service rendered.</p>		
_____ Parent/Guardian Signature	_____ Relationship	_____ Date
Sworn to and subscribed before me this _____, day of _____, 20____ My commission expires: _____		
_____ Notary Public, State of Florida – at Large		
_____ Who is personally known to me OR _____ Who has/have produced identification: _____		