

**New Student Application**



**Please complete the application & return with the following:**  
Enrollment fee - \$100 per student  
Medical Forms

**STUDENT INFORMATION**

|                         |                |     |       |
|-------------------------|----------------|-----|-------|
| Student Full Legal Name | Preferred Name | DOB | Grade |
| Student Full Legal Name | Preferred Name | DOB | Grade |
| Student Full Legal Name | Preferred Name | DOB | Grade |
| Student Full Legal Name | Preferred Name | DOB | Grade |

**STUDENT(S) RESIDE WITH:**

Mother & Father                     
  Mother & Step-father                     
  Father & Step-mother  
 Mother only                     
  Father only                     
  Grandparents  
 Other: Please specify \_\_\_\_\_

**FAMILY INFORMATION**

School district student(s) resides in: \_\_\_\_\_

Parents of this student are:    Married    Separated    Divorced    Single Parent    Mother Remarried    Father Remarried    Other: \_\_\_\_\_

**Father/Guardian (please circle)**

Name \_\_\_\_\_

If Guardian, Relationship to Student \_\_\_\_\_

Home Address- *please provide city and zip code* \_\_\_\_\_

Employer \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_      Work Phone Number \_\_\_\_\_      Ext. \_\_\_\_\_

Email Address \_\_\_\_\_

Church Congregation Name \_\_\_\_\_

Church Denomination \_\_\_\_\_

Stepmother's Name (if applicable) \_\_\_\_\_      Contact Number \_\_\_\_\_

**Mother/Guardian (please circle)**

Name \_\_\_\_\_

If Guardian, Relationship to Student \_\_\_\_\_

Home Address- *please provide city and zip code* \_\_\_\_\_

Employer \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_      Work Phone Number \_\_\_\_\_      Ext. \_\_\_\_\_

Email Address \_\_\_\_\_

Church Congregation Name \_\_\_\_\_

Church Denomination \_\_\_\_\_

Stepfather's Name (if applicable) \_\_\_\_\_      Contact Number \_\_\_\_\_

Student(s) Name: \_\_\_\_\_

**DIRECTORY**

I grant permission to have our home phone number, address and e-mail published in a school directory. \_\_\_ Yes \_\_\_ No

**PHOTO AGREEMENT**

I understand that periodically The Calvary Academy will use pictures taken of their students without their names in TCA publications including the website or promotional materials.

\_\_\_ Yes, I grant permission for pictures of my child to be used in this manner. \_\_\_ No, do not use my child's photo on any materials.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**COMMUNICATION**

TCA communication is sent via email and hard copy. To opt out of paper communication, please check here \_\_\_\_\_

Home phone number and one cell phone number or two cell phone numbers will be added to our "Phonevite" emergency phone messaging system.

**TRANSPORTATION OF STUDENTS**

The Calvary Academy will contract transportation from other companies for field trips. Parents will be advised of the mode of transportation and required to sign a consent and liability waiver form prior to the field trip or event.

The Calvary Academy Secondary Sports department will be under the umbrella of The Calvary Church (TCC) Sports Program and the students will be transported to sports events via TCC vans.

**PICK UP AUTHORIZATION INFORMATION AND EMERGENCY CONTACTS**

The following individuals have permission to pick up my child(ren) from school. I understand that I will still need to contact the school office should one of these individuals need to pick up my child(ren).

Persons Authorized \_\_\_\_\_

In the event of an emergency, please indicate the order in which these numbers should be called.

\_\_\_ Home: \_\_\_\_\_ Other: Name \_\_\_\_\_ Number \_\_\_\_\_

\_\_\_ Father's Work: \_\_\_\_\_ Other: Name \_\_\_\_\_ Number \_\_\_\_\_

\_\_\_ Father's Cell: \_\_\_\_\_

\_\_\_ Mother's Work: \_\_\_\_\_

\_\_\_ Mother's Cell: \_\_\_\_\_

**METHOD OF PAYMENT FOR TUITION (circle one)**

**FACTS Contract / Prepay / Employee** \_\_\_\_\_

I would like to receive information on the TCA Scholarship \_\_\_\_\_

Parent/Guardian Signature (Father) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature (Mother) \_\_\_\_\_ Date \_\_\_\_\_

Thank you for enrolling your child in TCA. If any of the information on this form changes, please contact the school office.

**FOR OFFICE USE ONLY-** Date Received: \_\_\_\_\_ Amount Paid: \$ \_\_\_\_\_ Payment Type: \_\_\_\_\_

|   |
|---|
| <b>The Calvary Academy</b><br>A Ministry of The Calvary Church since 1979 |
| <b>New Student Application</b>  |



Student(s) Name: \_\_\_\_\_

**STATEMENT OF COOPERATION**  
**\*\*\*PLEASE READ CAREFULLY AND SIGN BOTH SPACES BELOW\*\*\***

**I AGREE** to accept all regulations of the school in the applicant's behalf.

**I GIVE PERMISSION** for my child to take part in all school activities, including sports and school-sponsored trips away from school premises and absolve the school from liability to me or my child because of injury to my child at school or during any school activity.

**I PLEDGE** to pay our financial obligations to the school. I understand and accept that tuition is paid through FACTS Tuition Management. I also understand that if I have two concurrent failed payment attempts through FACTS that I will be assessed a \$15 late charge in addition to any fees that FACTS charges. I understand that if my account is not current at the end of the month, my child may be dismissed from school until my account is paid. For incidental charges I understand that a \$15 fee will be charged for each returned check. After two returned checks, only cash, cashier's checks or money orders will be accepted.

**I AGREE** that my child's records will be held until all financial obligations are met.

**I UNDERSTAND** that The Calvary Academy reserves the right to expel my child for failure to comply with the established regulations and discipline, or for failure to exhibit harmony with the philosophy of the staff and administration.

**I AGREE** to uphold and support the high academic standards of The Calvary Academy by providing a place at home for my child to study and to give him/her encouragement in the completion of homework assignments.

**I AGREE** to authorize and support this school to employ such discipline as it deems wise and expedient for my child. Further we agree to cooperate with the school by appropriately disciplining our child at home.

**I UNDERSTAND** the standards of The Calvary Academy do not tolerate profanity, obscenity in word or action, dishonor to God or the Word of God, disrespect to the personnel of the school or any form of worldliness.

**WE UNDERSTAND** that the school reserves the right to discipline or expel any student who does not cooperate (or whose parents do not cooperate) with the educational process, on or off campus. We understand the school does not tolerate conduct that violates biblical principles, dishonors God, or casts a poor reflection on the name and reputation of the school. We further understand the school has "zero tolerance" toward student involvement with alcohol, sexual misconduct, and/or assault or use/possession of a weapon.

**I AGREE** to attend Parent Orientation when the exact time of the meeting is announced.

**WE AGREE** to insure that our child arrives at school on time each day. We further agree to see that our child maintains regular attendance, and we understand that absences in excess of 10 days in a semester (without a written doctor's excuse) may result in failure for the semester.

**I HAVE READ** the Student Handbook and agree to encourage my child to comply therewith and will not criticize school rules to my child. We realize that to do so will make it difficult for him/her to maintain a right attitude.

**I AGREE** to support The Calvary Academy with a willing and cheerful attitude.

**I WILL NOT** criticize the administration and/or teachers of the school in the presence of my children and others.

**I WILL NOT** make critical comments publicly, but will seek a private meeting with the administrator when administrative decisions are reached and school policy is established with which I disagree.

**I HAVE READ** the Statement of Faith in the handbook and give permission to the school to teach this doctrine to my child.

**I HAVE CAREFULLY READ THE ABOVE TERMS AND PLEDGE, BY MY SIGNATURE, TO COOPERATE ACCORDINGLY.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_  
 (Parent or Guardian)

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_  
 (Parent or Guardian)

**THE CALVARY ACADEMY  
AUTHORIZATION TO RELEASE INFORMATION**

\_\_\_\_\_  
Student's Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M.I.

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Enrolling to enter grade:

\_\_\_\_\_ authorizes the release of records from the following school:

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
School/Institution Name

**Release any of the following records available:**

- Discipline Records- Suspensions/Expulsions
- Transcript of subjects and grades
- Attendance Records
- Standardized Test Results
- Health Records
- Court Orders (Custody, Restraining Orders, etc)
- All other personally identifiable data

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Fax

**The records may be released to:**

**The Calvary Academy  
11970 Kenn Road  
Cincinnati, OH 45240  
Attn: Mickey Gardiner**

**Phone: 513.674.9600  
Fax: 513.674.9602  
Email: [mickey@thecalvarychurch.com](mailto:mickey@thecalvarychurch.com)**

**If records are not available, please return our request indicating the reason:**

- No records available**
- Sending Partial Records**
- Records not release due to unmet financial obligations**

\_\_\_\_\_  
Registrar/Records Clerk

\_\_\_\_\_  
Date Responded

|   |
|---|
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**EMERGENCY CONTACT AND MEDICAL AUTHORIZATION**

\_\_\_\_\_  
 Student's full name (please print) Grade \_\_\_\_\_

In an emergency please contact \_\_\_\_\_ (\_\_\_\_\_) at \_\_\_\_\_  
Name Relationship Phone number

\_\_\_\_\_  
Name Relationship Phone number

\_\_\_\_\_  
Name Relationship Phone number

**Purpose** – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached or are unable to respond in a timely manner.

Please complete Part I or Part II (Part II on opposite side)

**Part I**

In the event reasonable attempts to contact the above have been unsuccessful or although contacted the response time will be lengthy, I hereby give my consent for (1) the administration of any treatment deemed necessary by a preferred physician or preferred dentist or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the preferred hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Preferred Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Preferred Dentist \_\_\_\_\_ Phone# \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Any facts concerning the student's medical history including allergies, medications, and any physical impairments to which a physician should be alerted, (additional space available on back of form).

\_\_\_\_\_

\_\_\_\_\_  
 Date Signature of Parent Address

**EMERGENCY CONTACT AND MEDICAL AUTHORIZATION – Page 2**

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

\_\_\_\_\_  
Student's full name (please print)

\_\_\_\_\_  
Grade

**Part II**

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Address

\_\_\_\_\_  
\_\_\_\_\_  
Continue from Part I : facts concerning the student's medical history including allergies, medications, and any physical impairments to which a physician should be alerted \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**The Calvary Academy**

A Ministry of The Calvary Church since 1979

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**NON-PRESCRIPTION MEDICATION** – Must be completed and returned

With your permission, non-prescription medication will be administered by the school’s nurse or other designated person as needed. Please be aware that we will have only non-prescription medications listed below available. Any other non-prescription medication will need to be provided by the student’s parent/guardian. This medication should come in the original container with expiration date visible. Label the container with the student’s name and bring to the school office. In addition it will be your responsibility to retrieve any remaining medication at the end of the school year. Medications remaining in the office after summer dismissal will be disposed of.

Student’s Name \_\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_

Pertinent medical information (allergies, medical conditions) \_\_\_\_\_

\_\_\_\_\_

Please indicate your preference below regarding the administration of non-prescription/over the counter medication (Please check if permitted):

Non-Prescription Medication:

- \_\_\_\_\_ Children’s Motrin (Ibuprofen)
- \_\_\_\_\_ Junior Strength Ibuprofen (Ages 6-11)
- \_\_\_\_\_ Children’s Tylenol (Acetaminophen)
- \_\_\_\_\_ Junior Tylenol Meltaways (Ages 6-11)
- \_\_\_\_\_ Tums – upset stomach
- \_\_\_\_\_ Benadryl/Allergy

Adult Tylenol is only given to students over 12 years or 100 pounds. All other students get children’s products.

- Ibuprofen
- Tylenol

Any other non-prescription medication must be provided by parents and kept in the school office. Female products must be sent with students.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please do not give my child any medication without my written or phone permission.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## **PRESCRIPTION MEDICATION**

(Complete only if your child will need to take prescription medicine during school hours)

School policy requires consent of the parent/legal guardian and a written order from the licensed prescriber before medication can be given to a student by school personnel. All requested information must be completed in full and returned to the school office.

No student is allowed to carry or place in his/her locker, lunch box, backpack, purse, etc., unapproved medication (this includes Tylenol). With few exceptions, medications will be stored and dosages taken in the school office.

Student's Name \_\_\_\_\_

DOB \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### **TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER**

The above named student is under my care for \_\_\_\_\_

Diagnosis

and should receive \_\_\_\_\_

Name of Medication

Dosage and Route

at the following times \_\_\_\_\_

Specific instructions for administration: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Effective date \_\_\_\_\_ Expiration date of this request \_\_\_\_\_

\_\_\_\_\_  
Licensed Prescriber Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone number

**MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE AFFIXED LABEL FROM THE PHARMACY. THE LABEL MUST SHOW THE STUDENT'S NAME, THE NAME OF THE MEDICATION, THE DOSAGE DIRECTIONS, AND THE PRESCRIBER'S NAME.**

### **TO BE COMPLETED BY PARENT/GUARDIAN**

I give my permission for the school's R.N. or designated person to administer the medication as prescribed above to my child and further agree to:

- 1) Submit to the school nurse a revised statement signed by the licensed prescriber of the above medication when any change in the original order occurs or is discontinued.
- 2) Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication.
- 3) Provide safe transportation of the medication to and from school.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**THIS PERMISSION FORMS IS NO LONGER VALID AFTER THE END OF THE SCHOOL YEAR**



**TCA SCHOOL HEALTH REPORT**

**Section I – To be completed by parent/ guardian**

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

PHYSIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

DENTIST: \_\_\_\_\_

PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

| Is your child having any of the problems listed below?              | Yes | No |
|---|-----|----|
| 1. Allergies or reactions: (For example, food, medication, or other |     |    |
| 2. Hay fever, asthma, or wheezing                                   |     |    |
| 3. Eczema or frequent skin rashes                                   |     |    |
| 4. Convulsion/ Seizures   |     |    |
| 5. Heart trouble  |     |    |
| 6. Diabetes   |     |    |
| 7. Frequent colds, sore throat, earaches (4 or more per year)       |     |    |
| 8. Trouble with passing urine or bowl movements                     |     |    |
| 9. Shortness of breath  |     |    |
| 10. Speech problem  |     |    |

Please explain any problem areas identified above:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does your child take any medication regularly?

Yes

No

If yes, what medication? \_\_\_\_\_

Reason for medication? \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Student's full name (please print) \_\_\_\_\_ Grade \_\_\_\_\_

**SECTION II – To be filled out by Physician**

**IMMUNIZATION RECORD**

| TYPE        | DATE | DATE | DATE | DATE | DATE | DATE |
|-------------|------|------|------|------|------|------|
| DPT         |      |      |      |      |      |      |
| TD          |      |      |      |      |      |      |
| POLIO       |      |      |      |      |      |      |
| MMR         |      |      |      |      |      |      |
| HIB         |      |      |      |      |      |      |
| Hepatitis B |      |      |      |      |      |      |
| Varicella   |      |      |      |      |      |      |
| Other       |      |      |      |      |      |      |
| Other       |      |      |      |      |      |      |

Please list and describe any allergies to medications, food, or environment

\_\_\_\_\_

\_\_\_\_\_

Has child been prescribed      Epipen \_\_\_\_\_      Inhaler \_\_\_\_\_

| Vision Tested? <input type="checkbox"/> Visual Acuity  | Normal | Under care | Referred | Urinalysis Done? <input type="checkbox"/> Sugar  | Normal | Under care | Referred |
|--|--------|------------|----------|--|--------|------------|----------|
| YES    NO <input type="checkbox"/> Ocular Muscles<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other<br>Date _____              |        |            |          | YES    NO <input type="checkbox"/> Albumin<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Microscopic<br>Date _____ |        |            |          |
| Hearing Test?<br>YES    NO <input type="checkbox"/> Audiometer<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other<br>Date _____ |        |            |          |  |        |            |          |
| Hemoglobin/ Hemotocrit Tested?<br>YES    NO<br><input type="checkbox"/> <input type="checkbox"/>   |        |            |          |  |        |            |          |

**PHYSICAL ASSESSMENT**

PLEASE CHECK ONE:

Entirely within normal limits

Abnormalities as follows:

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Is there any reason why the student cannot carry out full program of school work? Yes  No

If yes, what is the reason?

**SECTION III To be filled out by Dentist**

**DENTIST'S REPORT**

The following statements are applicable: (Please check)

\_\_\_\_\_ All necessary services have been performed

\_\_\_\_\_ No restorative services are required at this time

\_\_\_\_\_ Further treatment is indicated

\_\_\_\_\_ Further appointments have been arranged

Dentist's Signature \_\_\_\_\_