



# Student Application

BALTIMORE JUNIOR ACADEMY



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3006 W. Cold Spring Lane  
Baltimore, Maryland 21215  
Tel: (410) 542-6758  
Fax: (410) 542-7412

Dear Baltimore Junior Academy Applicant,

Congratulations on taking a significant step in ensuring the outcomes you desire for your child become reality. It is Baltimore Junior Academy's privilege to welcome you into our community of life-long learners who are being mentored to become leaders within their community and the world. As a Seventh-day Adventist Christian school, we deliver a strong academic curriculum in an environment promoting values and morals which reflect a loving God.

BJA is a school where success is modeled and replicated! Teachers understand that each child is unique by God's design, and as such, we are here to help them achieve their dreams and the possibilities are limitless. Our small class sizes supports equity in the teacher-student relationship while fostering a rigorous learning environment among students.

The partnership we will develop with you, your child, and his/her extended village of supporters will be critical for student growth and achievement. Our admission team is eager to meet with you and support you through the application process. Contact us at [info@bjacademy.org](mailto:info@bjacademy.org) or (410) 542-6758.

Warmest Regards,

*David Turner*

David Turner, Principal

## STUDENT INFORMATION

Student Last Name:		Student First Name:		Student Middle Name:	
Date of Birth:		Student Home Phone:		Student Cell Phone:	
Student email address:					
Student Home Street					
City		State		Zip	
Country:					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Ethnicity:		Enrolling into Grade Level:	
Denomination of Student		If Seventh-day Adventist, is student baptized?			Date of Baptism:
		Which church is student membership?			
Name of school transferring from:					
Address					
School Principal			School Phone:		

## PARENT/ GUARDIAN INFORMATION

<b>Check if Appropriate</b>	<input type="checkbox"/> Parents Married	<input type="checkbox"/> Guardian Relationship:	<input type="checkbox"/> Parents separated	<input type="checkbox"/> Parents Divorce	<input type="checkbox"/> Father deceased <input type="checkbox"/> Mother deceased
			*any custody documents must be on file at school		
<b>PARENT INFORMATION</b>	<b>MOTHER</b>			<b>FATHER</b>	
NAME OF PARENTS					
Parent Middle Name					
Date of Birth:					
Mobile Phone:					
Home Phone:					
Work Phone:					
Email address:					
Address if different than above					
Marital Status:					
Ethnicity:					
Denomination:					
Church Membership:					
Date of Baptism:					

# EMERGENCY FORM

**INSTRUCTIONS TO PARENTS:**

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Enrollment Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First

Child's Home Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)	
		Place of Employment: _____	Cell: _____
		Work: _____	Home: _____
		Place of Employment: _____	Cell: _____
		Work: _____	Home: _____

Name of Person Authorized to Pick Up Child (*daily*) \_\_\_\_\_  
Last First Relationship

Home Address: \_\_\_\_\_  
Street/Apt.# City State Zip Code

Telephone : Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Any Changes/Additional Information \_\_\_\_\_

**ANNUAL UPDATES** \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name \_\_\_\_\_ Telephone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

2. Name \_\_\_\_\_ Telephone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

3. Name \_\_\_\_\_ Telephone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

**Child's Physician or Source of Health Care** \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

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

**INSTRUCTIONS TO PARENT/GUARDIAN:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s): \_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Practitioner

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number

## MEDICAL RECORD

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

Address \_\_\_\_\_ SS Number \_\_\_\_\_

Grade \_\_\_\_\_

*History— Past illnesses and allergies. Please check those he/she has had.*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Ear Infections       |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Allergies, Hay Fever |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Penicillin           |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Other Drugs          |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Insect Bites  |   |

Explain briefly factors such as surgeries, serious accidents or injuries, congenital defects, speech defects, vision problems, which may affect the child's school experience.

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*Immunizations— As required by state law.*

Dose #	DTP Series 2,4,6 & 15 mths 4-6 Yrs	DTaP 15 mths & 4- 6 Yrs	HBV Series Birth, 2 & 6 Mths	Polio Series 2,4,6 Mths 4-6 Yrs	Hib 2,4,6 & 15 mths	Hep B 3 shots	TB Skin Test	Dose #	MMR 12 Mths & before 12 Yrs
1								1	
2								2	
3								Dose #	Varicella*
4								1	
5								2	

\*Blood test verification of immunity or chickenpox disease date may be entered lieu of vaccination date.

To the best of my knowledge the vaccines listed above were administered as indicated.

Physicians Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Parent's/Guardians Signature \_\_\_\_\_ Date \_\_\_\_\_

**TURN OVER**

## PHYSICAL EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

	<u>Normal</u>	<u>Abnormal</u>	<u>Not Examined</u>	<u>Explain Abnormalities</u>
<b>Skin</b>	_____	_____	_____	_____
<b>Eyes, Vision, Glasses</b>	_____	_____	_____	_____
<b>Nose &amp; Throat</b>	_____	_____	_____	_____
<b>Mouth, Teeth, Speech</b>	_____	_____	_____	_____
<b>Glands</b>	_____	_____	_____	_____
<b>Chest &amp; Lungs</b>	_____	_____	_____	_____
<b>Cardiovascular, Heart</b>	_____	_____	_____	_____
<b>Abdomen: Enlargement</b>	_____	_____	_____	_____
<b>Tenderness</b>	_____	_____	_____	_____
<b>Hernia</b>	_____	_____	_____	_____
<b>Spine, Back</b>	_____	_____	_____	_____
<b>Extremities</b>	_____	_____	_____	_____
<b>Genitourinary</b>	_____	_____	_____	_____
<b>Nervous System, Reflexes</b>	_____	_____	_____	_____
<b>Nutritional Status and General Appearance</b>	_____	_____	_____	_____

Recommendations for additional medical or dental care: \_\_\_\_\_

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling.      **YES**      **NO**

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted.

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

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**CONSENT FORM**

**MEDICAL**

We, the undersigned parents or guardian of said minor, do hereby consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instruction of said doctor or any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital.

<b>Student Name:</b>	<b>D.O.B.</b>
<b>Physician Name:</b>	<b>Phone:</b>
<b>If you are a member of an HMO, list the phone number:</b>	

It is further understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize Baltimore Junior Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to Mass Benefits Consultants or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and as valid as the original.

\_\_\_\_\_  
*Signature of Parents/Guardians of Student* *Date*

**PARENT/ GUARDIAN INFORMATION**

Name:	Name:
Phone Home:	Phone Home:
Cell:	Cell:
Work:	Work:

**PERSONS TO CONTACT IF YOU ARE UNAVAILABLE:**

Name:		
Phone Home:	Work:	Cell:
Name		
Phone Home:	Work:	Cell:

# Liability Waiver

*This form must be completed in its entirety each school year and submitted to the Registrar's Office before any student can be officially registered at BJA. The Consent to Treatment form is also required.*

To the best of my knowledge,

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*Printed Student's Name*

is in good physical condition and fully able to participate in regular school-related activities. I understand that there are risks/dangers involved in participation of school related activities. In consideration of my child being allowed to participate in this event, I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OR LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that might be sustained as a result of participating in school sponsored activities.

I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO Bring Legal Action to Baltimore Junior Academy, the Baltimore Junior Academy School Board, the Allegheny East Conference of Seventh-day Adventists, the Columbia Union Conference of Seventh-day Adventists, the North American Division of Seventh-day Adventists, or the Seventh-day Adventist World Headquarters, their officers, servants, agents and employees (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of actions whatsoever arising out of or related to any loss, damage or injury, including death, that may be sustained as a result of participating in school sponsored activities.

It is my expressed intent that this RELEASE AND HOLD HARMLESS AGREEMENT shall bind the members of my family, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVE, DISCHARGE AND CONVENTION TO Bring Legal Action the above named RELEASEES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be constructed in accordance with the laws of the State of Maryland.

In signing this release, I acknowledge and represent that I HAVE READ THE FOREGOING Waiver of Liability and Hold Harmless Agreement, UNDERSTAND IT AND SIGN IT VOLUNTARILY as my own free act and deed; no oral representations, statements or inducements, apart from the foregoing written agreements have been made; and I EXECUTE THIS RELEASE FOR FULL, ADEQUATE AND COMPLETE CONSIDERATION FULLY INTENDING TO BE BOUND BY SAME.

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*Signature of Parents/Guardians if Student is under 18 years of age*      *Date*



# Internet/Media/Cell Agreement

## INTERNET ACCEPTABLE USE AGREEMENT

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Our goal in providing this service is to promote educational excellence by facilitating resource sharing, innovation and communication. **To gain access to the Internet, both a parent/guardian and student must sign and return this form to the school.**

Baltimore Junior Academy has taken precautions to restrict access to inappropriate materials. However, it is impossible to control all materials, and a student may discover unsuitable information. Baltimore Junior Academy firmly believes that the valuable information and interaction available on the Internet far outweighs the possibility that users may procure material that is not consistent with the educational goals of Baltimore Junior Academy.

### The student and parent/guardian must sign their agreement to the following:

- The student is responsible for Christian behavior and communication on the school's computer network and will comply with school standards.
- If the student access inappropriate material **the school will not be liable** (*the student will forfeit network privileges and appropriate disciplinary and legal actions(s) will be taken*).
- Should I commit any violation my access privileges may be revoked, school disciplinary action may be taken and/or appropriate legal action.
- I understand and will abide by the Internet Acceptable Use Agreement.
- As a parent/guardian I understand this access is designed for educational purposes. However, I also recognize that it is impossible for BJA to restrict access to all inappropriate/unacceptable materials.
- I will not hold BJA responsible for materials acquired on the network.

I, \_\_\_\_\_, accept and will follow the terms of the agreement stated above.  
*Print Student Name*

I hereby give permission for my student to access the Internet at Baltimore Junior Academy.

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

\_\_\_\_\_  
*Date*

## MEDIA RELEASE: CONSENT FOR PUBLICATION OF WORK AND PHOTOGRAPHS

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I agree that, if selected, my son/daughter's work may be used in any school publication. I also agree that photographs and videos which include my son/daughter may be published and used subject to Baltimore Junior Academy's rules and guidelines.

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

\_\_\_\_\_  
*Date*

## CELL PHONE USAGE AGREEMENT

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I agree that, cell phones and electronic device are permitted at Baltimore Junior Academy for your convenience and are a privilege. Failure to follow the cell phone guidelines will result in the confiscation of the student's phone. Cell Phone use is not permitted during school hours and must be turned off and stored in the student lockers.

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

\_\_\_\_\_  
*Date*

**FIELD TRIPS AND TRAVEL**

\_\_\_\_\_ (child's name) has permission to participate in all sports and school sponsored trips away from the school premises throughout the current school year. I further understand that I may revoke permission for a specific field trip by written notice hand-delivered to the principal more than one day prior to the trip. Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I understand that there are risks/dangers involved in participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in this event, I assume responsibility for those ordinary and reasonable risks associated with travel activities.

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

\_\_\_\_\_  
Date

**ACCOMODATIONS (IEP, 504 Plans)**

Please be advised that \_\_\_\_\_ (child's name) has benefited from a previous/current accommodations plan that is documented and included as part of this application to Baltimore Junior Academy. I look forward to working with the educators at BJA to ensure this information is updated as needed.

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

\_\_\_\_\_  
Date

**REFUSAL TO VACCINATE**

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

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I have had the opportunity to discuss my decision not to vaccinate my child and still decline the recommended immunizations.

Parent's Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Parent's Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT AGREEMENT**

I have read the answers to the above questions and find that they are correct. I hereby agree to cooperate with the regulations and policies as written in the school handbook. I agree to assume financial responsibility for the above student and to pay bills promptly as outlined in the school handbook.

*I also understand no transcript of credits or diploma will not be released until my bill is paid in full.*

Parent Signature: \_\_\_\_\_

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

Parent Signature: \_\_\_\_\_

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