Adventist Education
A JOURNEY TO EXCELLENCE

Klamath Falls Adventist Christian School

2499 Main Street, Klamath Falls, OR 97601-2721
Ph. 541.882.4151 Fax: 541.882.4151 Email: wchdanielweston@aol.com

STUDENT ENROLLMENT APPLICATION

Legal Name of Student:

_____

Last First Middle

Applying for grade _____ School Year _____

Resident address: (If changes occur, it is the parents responsible to report that information)

_____

Street City State Zip

Home telephone _____

May we publish this information in the school directory? ☐ Yes ☐ No (If not checked, info will be Published)

Age_____ Birth date _____/_____/____ Place of Birth _____
Month Day Year (city & State)

Gender: _____ Student's SS# (required): _____ US Citizen? ☐ Yes ☐ No

Parents Religion (if any) _____Church membership at: _____
Child's Baptism date (if available): _____Church membership at:_____
Would you be interested in being an KFACS volunteer? ☐ Yes ☐ No

OTHER INFORMATION PERTAINING TO THE STUDENT

I. Persons authorized to pick up my student(s) (other than their parents):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

II. Previous School: (It is the parent's responsibility to send Records Transfer Form to previous school. We have included a "Records Transfer Form" in this packet.

Previous School Name _____
City _____ **State** _____ **Zip** _____
Phone _____ **Date last attended** _____

For School Use Only:
Birth Cert ___ Physical ___ Immuniz___ Date records requested: _____ Date records received: _____

(Check One) ☐ **Father/** ☐ **Stepfather/** ☐ **Guardian Information:**

_____

(Last Name) (First Name) (Middle Name)

Address: _____

(Street or PO Box (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Send *Newsletter* to your email? Y N

Would you be willing to volunteer? _____ Days available: _____

Time of day during the week: _____

Occupation: _____ Employer: _____

Marital Status: Married ____ Divorced ____ Single ____ Separated ____ Widowed____

(Check One) ☐ **Mother /** ☐ **Stepmother /** ☐ **Guardian Information:**

_____

(Last Name) (First Name) (Middle Name)

Address**:** _____

(Street or PO Box) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Send *Newsletter* to this email? Y N

Would you be willing to volunteer? _____ Days available: _____

Time of day during the week:_____

Occupation: _____Employer: _____

Marital Status: Married ____ Divorced ____ Single ____ Separated ____ Widowed____

With whom does the child live: both parents____ Father Only____ Mother Only___ Guardian____

If parents cannot be contacted in case of an emergency, please list other local authorized contacts:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Child's Doctor: _____ **Phone:** _____

I hereby give permission for the office staff at KFACS to give my child medications for pain, cough, itch, or indigestion as directed on the container. I understand, should a fever or severe pain be present, I will be notified immediately.
_____ parent/guardian initial _____ date.

My signature certifies that all information provided on this application is accurate, and I hereby authorize permissions as stated above.

_____ _____

Parent / Legal Guardian Signature Date