Student Contact Information

Full Name				Grade Entering	
Preferred Name			Date of Birth	_____ / _____ / _____	
Gender	M ___ F ___		Student Citizenship		
Address					
City		State		Zip Code	
Home Phone		Cell Phone			
Email					

Parent #1 Contact Information

Full Name					
Address					
City		State		Zip Code	
Home Phone		Cell Phone			
Email					

Parent #2 Contact Information

Full Name					
Address					
City		State		Zip Code	
Home Phone		Cell Phone			
Email					

Emergency Contact Information

Full Name			
Home Phone		Cell Phone	

Emergency Contact Information

Full Name			
Home Phone		Cell Phone	

Off Campus Travel

My student has permission to go off campus, after obtaining appropriate permission with the following persons:

Parents	___ yes	___no	Relatives	___ yes	___no
DAA Faculty	___ yes	___no	Parents of other DAA students	___ yes	___no
Own Vehicle	___ yes	___no			

Please specify if there are certain individuals with whom you DO NOT want your child to ride?

_____

_____

_____

Verbal Permissions

Selecting "yes" for the following options will allow you to give verbal permission over the phone.
I wish to be able to give verbal/phone permission for my student to be able to:

Use their car for educational, medical, work or family appointments: ___ yes ___no

Ride with another student during homeleaves: ___ yes ___no

Obtaining permission for excused/arranged absences: ___ yes ___no

I give my full permission for all the above checked items and accept full responsibility for any accidents or injuries which might be incurred by my child while participating in any of the above checked items.

Signature _____ Date _____

Medical Information

Student Name: _____

Parent 1 Name and Phone Number			
Parent 2 Name and Phone Number			
EC Name and Phone Number			
Health Insurance Company			
Policy #		Group #	
Name and Phone Number of Primary Doctor			
Name and Phone Number of Primary Dentist			
Allergies: _____			
Date of last Tetanus shot: _____		Pertinent Medical Information: _____	

Does the student have prescribed medications? _____ Yes _____ No
Please list any prescription medications that this student is taking:

Tylenol	___ yes	___no	Ibuprofen	___ yes	___no
Topical Antibiotic Ointment	___ yes	___no	Benadryl	___ yes	___no

Please note that we will not allow students to self-administer medications.

Consent to Treatment:

I, the undersigned parent or guardian of the above minor, do hereby consent to any X-ray examination, immunization,, anesthetic medical or surgical diagnosis or treatment and hospital service that may required to aid minor under the general or specific instruction of any physician the school or organization may call, whether such diagnosis or treatment is is rendered at the office of said physician or at a licensed hospital. 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 Dakota Adventist Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. I hereby authorize any hospital physician, or other person who has attended or examined the minor to furnish the insurance service, or its representative, any and all information with respect to any illness, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

I, the undersigned parent or guardian of the above minor, hereby authorize the school nurse/dean/EMT of Dakota Adventist Academy to give over-the-counter medications in the event of minor illnesses and/or injuries such as headaches, colds sore muscles, etc. All over-the-counter medications will be checked for compatibility with any prescription medication that your child may be taking. Please notify the school nurse of the medications your child is taking. If the condition persists, a medical evaluation will be obtained

Signature _____ Date _____

Education Information

Student Name					
List all schools attended from the 8th grade to the current year. Include online or correspondence classes					
8th Grade School		Phone Number			
School Address		Report Card Submitted?			
City		State		Zip Code	
9th Grade School		Phone Number			
School Address		Report Card Submitted?			
City		State		Zip Code	
10th Grade School		Phone Number			
School Address		Report Card Submitted?			
City		State		Zip Code	
11th Grade School		Phone Number			
School Address		Report Card Submitted?			
City		State		Zip Code	

Residence Information

Please check all that apply:					
Dorm Student		Day Student		Host family needed for breaks	
If needing host family for breaks, please answer the following questions.					
Do you have any dietary restrictions?					
Are you allergic to pets?					
Is there additional information your host family will need?					

References

1. Principal/ Teacher Name		Phone Number			
Address					
City		State		Zip Code	
2. Pastor/Coach Name		Phone Number			
Address					
City		State		Zip Code	
3. Adult (non-family) Name		Phone Number			
Address					
City		State		Zip Code	