NORTHERN OHIO
N. A. A.
Show Nurture Teach Empower
ADVENTIST ACADEMY

Home School Co-op Registration

Student's Legal Name _____
Last First Middle

Address _____
Street

_____
City State Zip

Date of Birth _____ Gender _____ Grade _____

Family Information	Father	Mother	Guardian
Name			
Home Address (If different from above)			
Home Telephone			
Cell Phone			
Email Address			
Occupation			
Work Phone			
Church Affiliation			

I/we hereby also authorize the release of my/our child's photograph for school publications, i.e., calendar, bulletin, website, etc.

List of person(s) to whom this child can be released: (please print)

_____ _____ _____ _____

My Child's School History:

_____

_____

We desire to enroll _____ in the Northern Ohio Adventist Academy's Home School Co-op Program for the _____ school year and agree to abide by the regulations of the school and pledge our full cooperation.

_____ _____

Student Signature Parent/Guardian Signature Date

Medical Update – required annually **School Year:** _____

Student Name: _____ Birthdate: _____ Grade: _____

Contact Information

Parent/guardian 1: _____ Phone _____ Phone _____
Parent/guardian 2: _____ Phone _____ Phone _____
Additional contact: _____ Phone _____ Phone _____
Additional contact: _____ Phone _____ Phone _____

Consent to Treat

I authorize the additional contact people listed to pick up and transport the above named student should that student become ill or injured and I am unable to be reached. I also authorize EMS and hospital staff to transport and treat the above named student in the event of an emergency.
Parent/guardian signature _____ Date _____

Provider information

Physician _____ Phone _____
Dentist _____ Phone _____
Insurance Carrier _____ Insurance ID _____

Required forms:

- Immunization record for all new and Kindergarten students, updated **Tdap** for all 7th grade students
- Medication Authorization Form for all students with prescription medications (Epi Pens, Inhalers, and all other routinely prescribed medications required at school or on school-related trips)

(Please submit these required forms before/on the first day of school. Note the Med Auth. Form requires a physician's signature.)

Prescription Medications ***(please provide the physician signed Medication Authorization Form for school or trip purposes.)***

___Epi Pen _____
___ Inhaler _____
___ Other Medication: _____
Please list other meds _____

*dose, frequency and special instructions will be provided on the required Med Auth form.

Medical Conditions		
___ Anaphylaxsis	Please list specific allergen(s):	Please list typical reaction to allergen
Allergies:		
___ Food	_____	_____
___ Insect	_____	_____
___ Environmental	_____	_____
___ Asthma	___ Diabetes	___ Epilepsy ___ Other
___ Vision wears ___ glasses ___ contacts		___ Hearing wears ____aides

Over-the-Counter Medication is permitted with parent permission (please sign to permit or decline)

___ I authorize permission for the above named student to receive Over-the-counter medication if needed and as directed on the package label. Please do NOT give _____ weight _____
___ I DECLINE, please do NOT give this student ANY Over-the-counter medication.
Parent/guardian signature _____ Date: _____