



Worcester Seventh-day Adventist School  
2 Airport Drive  
Worcester, MA 01602

## Enrollment Application

### Student Information

Student's Name: \_\_\_\_\_  
*Last First Middle*

Date of Birth: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_  
*Month/Day/Year Include Country if not United States*

Primary Language Spoken: \_\_\_\_\_ Other Languages Spoke: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
*Street City/Town State Zip Code*

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ With whom does the student live with? \_\_\_\_\_

Church Membership: \_\_\_\_\_ Address: \_\_\_\_\_

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### Father's Information

Father's Name: \_\_\_\_\_  
*Last First Middle*

Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
*Street City/Town State Zip Code*

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Church Membership: \_\_\_\_\_ Address: \_\_\_\_\_

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### Mother's Information

Mother's Name: \_\_\_\_\_  
*Last First Middle*

Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
*Street City/Town State Zip Code*

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Church Membership: \_\_\_\_\_ Address: \_\_\_\_\_

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Please list the names and ages of all brothers and sisters: \_\_\_\_\_

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## Confidential – Medical Information

Student's Name: \_\_\_\_\_  
*Last First Middle*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
*Month/Day/Year*

Please list any allergies: \_\_\_\_\_

Please list any information that would be helpful in treating your child in a medical emergency: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

If an emergency arises the school will first attempt to contact one of the parents. If we are unable to reach a parent who should be contacted?

### Emergency Contact

Please Provide Two

Name: \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
*First Last*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
*First Last*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Optional Medical Information Release

\*\*\* Note: This is not consent to treat, this is an information release. \*\*\*

I hereby authorize the school to release medical information about my child when they believe it is in the best interest of my child for medical reasons. This will remain in effect until my child is withdrawn from this school or until I make a written request to change it.

Parent Signature: \_\_\_\_\_ Parent's Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_



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## Contact Information

(one per family)

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

### Father's Information

Father's Name: \_\_\_\_\_  
*Last* *First* *Middle*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ I check my email:  hourly  daily  weekly  not often

Important messages will get to me by:  e-mail  mail  with student

### Mother's Information

Mother's Name: \_\_\_\_\_  
*Last* *First* *Middle*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ I check my email:  hourly  daily  weekly  not often

Important messages will get to me by:  e-mail  mail  with student

### Emergency Contact Information

Name: \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
*First* *Last*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
*First* *Last*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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Other important information to the teacher:

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## Continuing Consent to Treatment

We, the undersigned parents or legal guardians of \_\_\_\_\_ do hereby consent to 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 instructions of \_\_\_\_\_ 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. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the school.

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 **Worcester Seventh-day Adventist School** or to the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school entrusted with the custody of said minor.

Father's Signature: \_\_\_\_\_ Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Mother's Signature: \_\_\_\_\_ Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Name (print): \_\_\_\_\_ Date: \_\_\_\_\_



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508-753-4732

### Alternative Pick Up Plan

All students MUST be picked up Monday – Thursday by 3:30pm and Friday by 12:15pm. If you are unable to pick up your child by 3:30pm on Monday-Thursday and 12:15pm by Friday you must have a plan in place. To prevent invoking the state's laws against child neglect/abandonment please complete this form.

Parent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_, MA Zip: \_\_\_\_\_

Children: \_\_\_\_\_ (age) \_\_\_\_\_ (age) \_\_\_\_\_ (age)

Please number the following options 1-3 in the order in which you would prefer us to proceed when your child is not picked up by 3:30pm.

\_\_\_\_ City bus pass (you are responsible for teaching your child how to get home using the bus)

\_\_\_\_ Contact a childcare to pick up your child. You must provide documentation that your child is registered at the daycare and that the daycare provides transportation from our school to their facility. See back of this page for suggestions.

Name of childcare: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_ Contact a pick up person that you have designated. They must pick up the child within 10 minutes of being contacted by the school.

Name of pick up person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_

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

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



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## Photo and Video Permission

A picture is worth a thousand words. During the school year we photograph and video tape school activities for school newsletters, school promotions, conference promotions, the local press, and sometimes because we have student teachers who use video to evaluate their work in our classroom. We are required to get your permission to photograph or videotape your child for school purposes.

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

I give permission for my child to be photographed or videotaped for school purposes.

Parent Signature: \_\_\_\_\_ Name (print): \_\_\_\_\_ Date: \_\_\_\_\_



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## School Handbook Acknowledgement Form

I have received a current copy of the school handbook and understand that the student and parent(s) / guardian(s) are responsible for knowing and abiding by its content. I understand that a student that is not able to fully read the material in the handbook is still expected to follow all of its content and agree that in such a case the parent(s) / guardian(s) take full responsibility for the student's knowledge and understanding of the contents of the school handbook.

I understand that the Yearly Asbestos Notification required by law is printed in the handbook and my signature below acknowledges receipt of that notification.

The handbook I received was last revised on:

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Student Name(s):

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Parent / Guardian Name (please print)

Parent / Guardian Signature

Date

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Parent / Guardian Name (please print)

Parent / Guardian Signature

Date