



Okeechobee Adventist Christian School

Application for Admittance

Student Name: _____

Address: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Grade : _____

Last School Attended: _____ Phone: _____

Parent Information:

Father: _____ Phone: _____

Address: _____

Custody: _____

Financial Responsibility: Y N

Employer: _____

Mother: _____ Phone: _____

Address: _____

Custody: _____

Financial Responsibility: Y N

Employer: _____

Guardian: _____ Phone: _____

Address: _____

Relationship: _____

Financial Responsibility: Y N

Employer: _____



Behavior Contract:

We the undersigned, have read and discussed the rules and procedures outlined in the school handbook, and we agree to abide by these rules.

We understand that failure to follow these rules may result in disciplinary actions which may include probation, suspension, or expulsion.

We understand that the first quarter of the year is a probationary period for all students and that the Board has the right to ask any student to leave at any time.

We understand that students and parents are required to attend any extracurricular events such as school programs, special music in the church, and Home & School meetings.

We understand that failure to pay tuition may result in suspension or expulsion, and that unpaid tuition may be reported to the IRS as income.

Please sign and print your name:

Student: (print) _____ Date: _____

Signature: _____

Parent: (print) _____ Date: _____

Signature: _____

Witness: (print) _____ Date: _____

Signature: _____



Consent to Treatment Okeechobee Adventist Christian School

This form must be completed at the beginning of each school year to cover the activities for that year. A copy of each student form must be taken on OACS's off-campus activities.

Students Full Name: _____

Age _____ Date of Birth (month/day/year) _____

Address:

Parent/Guardian Information:

Father/Guardian: _____

Business Phone: _____ Home Phone: _____

Mobile Phone: _____

Mother/Guardian: _____

Business Phone: _____ Home: _____ Cell: _____

Please describe allergies to substances and medications:

If on regular medication, please specify: _____

Family Physician Name and Office Phone:

Please give the name of a relative or friend who has consented to be an emergency contact for your child in case of illness or accident until you can be reached. **In case of any changes in the named person, notify the school in writing.**

Name: _____

Phone: _____

The above-named student is _____ is not _____ covered by health insurance.

Present Health Insurance Company

Policy Number

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above-named student as shall be necessary in the medical opinion of the doctor rendering service.

Signature of parent or guardian

date

Notary: _____ date _____