



A CHRISTIAN K-8 GRADE SCHOOL

PO Box 1025 2702 Adams Ave. La Grande, OR 97850 (541) 963-6203

Application for Admission

School Year: _____

Student Information

Child's Full Legal Name _____ Preferred First Name: _____

Home Address _____

City _____ State _____ Zip _____

Grade Entering _____ Date of Birth ____/____/____ Age _____ Sex M F

Student lives with Father () Mother () Grandparent () Step Parent ()

Preferred contact person: _____

During school # to reach you _____ Home ☐ Cell ☐ Work ☐ Texting: YES ☐ NO ☐

Evening # to reach you _____ Home ☐ Cell ☐ Work ☐ Texting: YES ☐ NO ☐

Family Information

Parent/Guardian- _____

Parent/Guardian- _____

Relationship _____

Relationship _____

Address _____

Address _____

Home Phone _____

Home Phone _____

Cell Phone _____

Cell Phone _____

Work Phone _____

Work Phone _____

Church affiliation _____

Church affiliation _____

Email address _____

Email address _____

Names and ages of other children in the home: _____

Emergency Contact in case parent cannot be reached:

Name	Relationship	Phone number
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Name	Relationship	Phone number
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Name	Relationship	Phone number
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Authorization to Release Information

We, the under signed parents or guardian of _____, a minor, do hereby consent to any 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 _____, M.D., (phone # _____) or any physician the school or organization 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 or other organization. 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 La Grande Adventist School or the physician to exercise the best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school or organization entrusted with custody of said minor. We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to CHRISTIAN EDUCATORS INSURANCE TRUST, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320d and 45 CFR 160 through 164. A Photostat copy of this authorization shall be considered as effective and valid as the original.

MY CHILD IS ALLERGIC TO THE FOLLOWING FOODS/MEDICATIONS:

Child's blood type (in case of emergency) _____

Does your child take any maintenance medication? **YES** **NO**

Condition _____ Name of Medication _____

Dosage _____ How often/Time of Day _____

Signature of parent or guardian

Date