

Victory Christian Academy
310 Carolina Avenue * Gastonia, NC 28052
Phone: 704-865-7132

Registration 2011 - 2012

I, _____, hereby make application for the admission
(Name of Parent or Guardian)
of my child to Victory Christian Academy and submit the following data for your information.

Child's Name: _____ **Grade:** _____
(Last) (First) (Middle)

Student's Social Security Number: _____ - _____ - _____ Phone: _____

Address: _____
(Street) (City) (State) (Zip Code)

Date of Birth: ____ / ____ / ____ Race: _____ Sex: _____

Place of Birth: _____

Father's Name: _____ **Phone:** _____

Social Security #: _____ - _____ - _____ Drivers License #: _____ State: _____

Address: _____
(Street) (City) (State) (Zip Code)

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Mother's Name: _____ **Phone:** _____

Social Security #: _____ - _____ - _____ Drivers License #: _____ State: _____

Address: _____
(Street) (City) (State) (Zip Code)

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Church Preference : _____ Check if Member : _____

Marital Status : Married _____ Divorced _____ Separated _____
Father : Deceased _____ Remarried _____
Mother : Deceased _____ Remarried _____

Pupil lives with :
Both Parents _____ Father _____ Mother _____ Guardian _____

Language spoken in home : _____

	Number Older	Number Younger	Number in School
Brothers :	_____	_____	_____
Sisters :	_____	_____	_____

IN MAKING APPLICATION, I AGREE :

1. My child will go on all scheduled field trips and other school activities. (state otherwise) _____
2. The school has full discretion in the classroom discipline of my child.
3. The administration has full responsibility for level placement of my child.
4. To abide by the dress code.
5. The school reserves the right to dismiss any student who does not respect its spiritual and moral standard or cooperate in the educational process.
6. My cooperation is expected in :
 - (a) Regular Tuition Payments
 - (b) Practical Help
 - (c) Faithful Prayer

Signature of both parents preferred, one will be accepted.

Father : _____ Mother : _____

Who will be responsible for picking up your child(ren)?

Father : _____ Mother : _____

Other : _____ Relationship : _____

INFORMATION ABOUT YOUR CHILD:

Does your child have any known allergies (such as dust, drugs, plants, animals, food, bee sting, etc.) If yes, what are they? _____

Please give any information concerning your child which will be helpful in his experience in group living (such as play, eating habits, special fears, special likes and dislikes.) _____

EMERGENCY CARE INFORMATION:

Name of child's doctor: _____ Office Phone: _____

Office Address: _____
(street) (city) (state) (zip code)

Name of child's dentist: _____ Office Phone: _____

Office Address: _____
(street) (city) (state) (zip code)

Hospital Preference: _____

If neither father nor mother (or guardian) can be contacted, call:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Date: _____ Signature of Parent or Guardian: _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian. Provisions will be made for adequate and appropriate rest and out-door play.

Signature of Operator: Bobby L. Culley

Health/Accident Insurance Information:

Name of Insurance Company: _____

Policy #: _____

Insured's Name: _____

VCA Insurance is Secondary Coverage: Church Mutual Insurance
Policy# 042657-02-015585
3000 Schuster Lane, Merrill Wisconsin 54452

STUDENT MEDICAL REPORT

Name of Child : _____ Age : _____ Birth Date : _____

Name of Parent : _____

MEDICAL HISTORY
(May be completed by parent)

1. Previous hospitalization : Yes _____ No _____ If so, Why? _____

2. Is Child allergic to anything? : Yes _____ No _____ If so, what? _____

3. Any previous diseases or illness : Yes _____ No _____ If so, what? _____

4. Any operations? Yes _____ No: _____ If so, for what? _____

5. Any physical handicaps? Yes _____ No _____ If so, what? _____

6. Is child under care of a doctor? Yes _____ No _____ If so, for what reason? _____

7. Any history of mental retardation? Yes _____ No _____

8. Any history of convulsions? Yes _____ No _____

9. Any history of diabetes in family? Yes _____ No _____

10. Any history of heart trouble? Yes _____ No _____

(Parent Signature)

Dear Parents,

Enclosed is a statement of disciplinary practices. We want to inform you of our policy. Please read the list below and return the slip of paper with your signature on it. We need this for your child's file.

Thank you,
Danny Hoell
Administrator

WE DO NOT SPANK THE CHILD, HOWEVER, THE PARENT CAN USE THEIR OWN JUDGEMENT.

1. BEFORE USING DISCIPLINARY RULES WE FIRST TALK TO THE CHILD. WE WANT THE CHILD TO UNDERSTAND WHAT HE/SHE IS DOING WRONG.
2. IF TALKING TO THE CHILD DOESN'T WORK. WE WOULD THEN LET HIM LOSE A TURN IN A GAME OR IN THE PLAY TIME TAKE AWAY A TOY HE ENJOYS PLAYING WITH.

DISCIPLINARY RULES:

1. THINKING CHAIR (ABOUT 5 MINUTES)
WE EXPLAIN TO THE CHILD WHAT HE/SHE IS DOING WRONG.
2. STANDING IN THE CORNER (ABOUT 5 MINUTES)
3. WHEN THE CHILD CONTINUES TO CAUSE PROBLEMS WE WILL CALL THE PARENTS IN FOR A CONFERENCE.

STATEMENT OF DISCIPLINARY PRACTICES

DATE OF ENROLLMENT : _____

I, _____, the parent, the guardian or the full-time
(Parent's Signature)

custodian of _____, do acknowledge and agree to the
(Child's Name)

disciplinary practices of South Gastonia Church of God Day Care Center. These practices have

been discussed with me and I received a copy of the discipline policy on _____.
(Date)

Children's Medical Report

Name of child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No _____ Yes _____ If yes, what?

2. Is child under a doctor's care? No _____ Yes _____ If yes, for what reason?

3. Is the child on any continuous medication? No _____ Yes _____ If yes, what?

4. Any previous hospitalization? No _____ Yes _____ If yes, when and for what?

5. Any history of significant previous diseases or recurrent illness? No _____ Yes _____;
diabetes No _____ Yes _____; convulsions No _____ Yes _____;
heart trouble No _____ Yes _____; if others, what/when? _____
6. Does the child have any physical disabilities? No _____ Yes _____ If yes, describe

Signature of Parent or Guardian _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ GU _____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ date _____ Normal _____ Abnormal _____

Should activities be limited? No _____ Yes _____ If yes, explain: _____

Any other recommendations: _____

Signature of authorized examiner/title _____

Date of Examination _____ Phone # _____

(continued on back)

Office Address
(may use address stamp)

C. Immunization History: The day care operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record.

G.S 130A-155(b) requires all day care facilities to have this information on file.

Enter date of each dose – Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP/DT					
*Polio					
**Hib					
*MMR (Combined Doses)					
Measles (Single Dose)					
Mumps (Single Dose)					
Rubella (Single Dose)					
***Hepatitis B					
****Varicella					

* Required by State law
 ** Required by State law for children born on or after 10/1/91.
 *** Required by State law for born on or after 7/1/94
 **** Required by State law for children born on or after 4/1/2001