

LELAND CHRISTIAN ACADEMY

A MINISTRY OF FBC LELAND

PRESCHOOL APPLICATION

517 VILLAGE ROAD NE

LELAND NC 28451

910-371-0688

WWW.LELANDCHRISTIAN.ORG

For Office Use Only

Start Date _____

Date Received _____

Enrollment Fee _____

Class to Enter _____

Medical Form _____

Immunizations _____

New Student Form _____

Tuition Express Form _____

Waiting List _____



Child's Full Name:

Preferred Name: _____

Applying for which program? INFANT TODDLER PK2 PK3 PK4 Date of Birth: _____ Male Female *(Please circle)*

Current address: _____

City: _____

State: _____

ZIP Code: _____

Phone: _____

Previous School/Day Care attended: _____

Father/Guardian Name:

Father Stepmother Legal Guardian *(Please circle)*

Address if different from above: _____

City: _____

State: _____

Zip Code: _____

Email: _____

Home/Cell Phone: _____

Work Phone: _____

Employer: _____

Position: _____

Mother/Guardian Name:

Mother Stepmother Legal Guardian *(Please circle)*

Address if different from above: _____

City: _____

State: _____

Zip Code: _____

Email: _____

Home/Cell Phone: _____

Work Phone: _____

Employer: _____

Position: _____

Applicant lives with(circle all that apply): Mother Father Legal Guardian Stepmother Stepfather Other

If separated/divorced, who has primary custody?(circle one): joint mother father other (please explain)

*Legal documentation may be required

Other Children in the Family

Name: _____

Age: _____

Grade: _____

Name: _____

Age: _____

Grade: _____

Name: _____

Age: _____

Grade: _____

Current Church:

Health Care Needs: For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes___ No___

Please list any food/drug allergies and the symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns. _____

List any types of medication taken for health care needs. _____

List any particular fears or unique behavior characteristics the child has _____

Pediatrician/Family Physician: _____ Practice: _____ Phone: _____

Hospital Preference: _____

INFANT	TODDLER	PK2	PK3	PK4	Please indicate the program for which you are applying
5 Days: FT	5 Days: FT	5 Days: FT	5 Days: FT	5 Days: FT	
		5 Days: ½	5 Days: ½	5 Days: ½	
		M-W-F: FT	M-W-F: FT		
		M-W-F: ½	M-W-F: ½		

We first learned of LCA through (circle one): Internet Church Newspaper/Magazine Realtor Current LCA family _____

Persons to whom the child may be released (other than parent/guardian), as authorized by the person who signs this application. Children may only be released to individuals listed on the application.

If neither Father nor mother(guardian) can be contacted please call

Name:	Relationship to child:	Phone:	
Name:	Relationship to child:	Phone:	
Name:	Relationship to child:	Phone:	
Name:	Relationship to child:	Phone:	
Name:	Relationship to child:	Phone:	
Name:	Relationship to child:	Phone:	

FATHER/GUARDIAN SIGNATURE:

DATE:

MOTHER/GUARDIAN SIGNATURE:

DATE: