



# LELAND CHRISTIAN ACADEMY

## A MINISTRY OF FBC LELAND

### KINDERGARTEN APPLICATION

517 VILLAGE ROAD NE

LELAND NC 28451

910-371-0688

WWW.LELANDCHRISTIAN.ORG

For Office Use Only

Date Received	_____
Acceptance	_____
Application Fee	_____
Enrollment Fee	_____
Medical Form	_____
Immunizations	_____
Birth Certificate	_____
New Student Form	_____
Tuition Express Form	_____
Waiting List	_____

**Child's Full Name:** \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Previous School/Day Care attended: \_\_\_\_\_ Male Female *(Please circle)*

Current address: \_\_\_\_\_

**Father/Guardian Name:** \_\_\_\_\_ Father Stepfather 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:

I/We authorize LCA to obtain all scholastic records from all previous schools:  Yes  No

Has the student received special help for reading or learning difficulty?  Yes  No

Has the application been diagnosed with ADD or ADHD?  Yes  No

**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: \_\_\_\_\_

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

Has the applicant received special help for reading or learning difficulty?

Yes  No

Has the applicant been diagnosed with ADD or ADHD?

Yes  No

Has the applicant ever been retained?

Yes  No

Is the applicant currently taking any medication?  Yes  No If yes, what? \_\_\_\_\_

Please explain any special need, condition, illness, disease, allergy, physical disability or fear that has affected or may affect your child's general health, schoolwork or physical activities engaged in during a school day. Are there currently any behavioral, psychological or educational evaluations, treatments or interventions? \_\_\_\_\_

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

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

**FATHER/GUARDIAN SIGNATURE:**

**DATE:**

**MOTHER/GUARDIAN SIGNATURE:**

**DATE:**