Scappoose Adventist School

2021-2022 PK – 8TH GRADE

STUDENT INFORMATION

FOR OFFICE USE ONLY:
_____ Application Fee Paid
_____ Financial Clearance/QB
_____ Acceptance/Renweb
Student ID

STUDENT INFORMATION

Student's Name (Last, First, Middle)	Gender (circle) M F	Grade Level: 2021-2022
Birth Place	Age	Birth Date
Last School Attended:	Mailing Address	Denomination/Church

STUDENT PLEDGE:

As a student of Scappoose Adventist School, I will:

- show respect to all
- demonstrate a positive and caring attitude
- do my best in school
- use my strengths and abilities to serve others
- take responsibility for my actions
- care for school property
- complete my work and prepare for tests
- seek help when I encounter problems
- uphold the principles and guidelines of Scappoose Adventist School

Signed: _____ Date _____

Will you need Before & After School Child Care? Yes No If you opt out of this program, emergency after school care will be provided up to 3x/year without student enrollment, but at a higher hourly rate.

54287 Columbia River Highway . Scappoose, OR 97056
Phone 503 543-6939. Fax 503 543-6944 . info@sasonline.org . www.sasonline.org

PERSONAL INFORMATION:

Has your student had his/her vision and hearing checked by a healthcare provider within the past year? ◯ Yes ◯ No
Are you aware of any medical concerns or issues that could affect your student's experience? ◯ Yes ◯ No
Are you aware of any academic challenges or needs that could affect your student's success? ◯ Yes ◯ No
Are you aware of any behavioral issues that could affect your student's success? ◯ Yes ◯ No
Has your student ever been suspended or asked to withdraw from school? ◯ Yes ◯ No
Please explain the details of all "yes" answers to the above questions: _____

_____

Note: Because vision and hearing impairments may greatly impact a student's ability to learn, we request all PK and Kindergarten students have their eyes and ears tested. Health professionals recommend students entering 6th grade be tested as well.

CONTINUING CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

Name of Physician	Phone
Name of Dentist	Phone
Hospital Preference	Phone

List any restrictions or allergies to drugs or food _____ ___

List medications taken regularly _____

List any other pertinent medical information _____
_____

I, the undersigned parent/guardian of _____, a minor, do hereby consent to any and all necessary medical treatment and hospital services that may be required in the event of an emergency or injury. If it is reasonable to do so, the school office will try and reach the above mentioned physician for advice for treatment. It is further understood that I, the parent/guardian, will be notified of incident as soon as reasonably possible.

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 the custody of said minor.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to General Conference Insurance Service, 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. A copy of this authorization shall be considered effective and valid as the original.

I give permission to Scappoose Adventist School faculty to give my student over the counter medications such as (circle) Advil, Aspirin, Benadryl, Tylenol or cough drops.
Other _____ ◯ Yes ◯ No ◯ Call me before you give the medication

Parent or Guardian Signature _____ Date _____

Witness