HOSPITALIZATIONS:

List reasons and approximate dates

OPERATIONS:

List reasons and approximate dates

SERIOUS INJURIES

List of injuries and give approximate dates

PREVIOUS BROKEN OR DISLOCATED BONES

MEDICATION Student is presently prescribed: _____

ARE YOU ALLERGIC TO ANY MEDICATION'S/FOODS? ____YES _____NO

LIST EACH DRUG/FOOD, AND HOW OFTEN IT IS TAKEN:

ALL MEDICINE MUST BE IN ORIGINAL PRESCRIPTION CONTAINER. SCHOOL PERSONNEL WILL NOT ADMINISTER OVER THE COUNTER MEDICINE.

(PARENTS MUST PRESENT I.D. IN PERSON FOR OFFICE STAFF TO NOTARIZE)

EMERGENCY MEDICAL AUTHORIZATION:

I hereby authorize the agents of Faith Outreach Academy to give consent for any and all necessary medical care for my child while he/she is involved in any Faith Outreach Academy program.

Father's Signature Date ***OR*** Mother's Signature Date

STATE OF FLORIDA, COUNTY OF HILLSBOROUGH

Before me, the undersigned authority, personally appeared _____ who has shown Identification_____ Number_____ Expiration_____

Witness by my hand and official seal this _____day of _____, _____

Notary Public, State of Florida

Renewal Registration Form

Date: _____

Child's Name: _____

Date of Birth: _____ Age: _____

Parent/Guardian Name: _____

Address: _____

Email Address: _____

Cell Phone: _____ Work Phone: _____

Last school grade completed: _____ Grade Entering: _____

Allergies/Medical Information: _____

_____

Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name(s) of person(s) who may pick up this child from school:

_____

Statement of Cooperation

In making application for my child, it is my desire to have him or her complete the school year 2026-2027. It is my understanding that the policy of the school is to make no refunds on registration or other fees. I give Faith Outreach Academy permission for my child to take part in all school activities, including field trips, sports activities, and school-sponsored trips away from the school premises. I release the school from liability to me or my child because of any injury to my child at school, in route to, or during school activity. I do, however, expect proper supervision of my child at all times. I have signed a Consent and Release Form. Should legal action, for any reason, be taken against Faith Outreach Academy or any employee or agent thereof on my child's behalf, and the school or its agent is not found at fault, I agree to pay any attorney fees, court fees, damages or any other costs that Faith Outreach Academy or its agents should incur to defend itself from such action. I confirm that I have carefully read the Consent and Release Form and know the contents thereof. I also understand that there are many pictures taken or videos of various events for publication in yearbook or possible television broadcasting. Payment dates will be strictly enforced; failure to comply may result in suspension or dismissal of my child. Excessive tardiness, early releases or absences may lead to academic failure and ultimately dismissal. Negative actions and attitudes may result in dismissal. Faith Outreach Academy has the right to search students lockers and belongings.

Violation of rules established in the handbook will be followed through with discipline in all cases. I have read the student handbook and support the schools policies. Parents are required to attend all Parents-Teacher Meetings. Parents and students must adhere to the academy's dress policy. Parents must actively participate in volunteering and fund-raising. Misconduct or moral lapses in conduct of a student will be strictly disciplined to this application is grounds for dismissal from Faith Outreach Academy.

Parent/Guardian Signature: _____ Student Signature: _____

FAITH OUTREACH ACADEMY

STUDENT'S MEDICAL & HEALTH RECORD

GENERAL INFORMATION:

NAME: _____ D.O.B._____ SOC. SEC: _____SEX: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

FATHER'S NAME: _____PLACE OF EMPLOYMENT: _____PHONE:___ MOTHER'S NAME: _____

PLACE OF EMPLOYMENT: _____PHONE: _____ FATHER'S/ S.S. NUMBER: _____

_____ MOTHER'S/ S.S. NUMBER: _____ EMERGENCY CONTACT: _____

_____ RELATIONSHIP: _____ ADDRESS: _____

_____ CITY: ____ STATE: ____ ZIP CODE: __ PHONE: _____

_____ WORK PHONE: _____ PHYSICIAN: _____

PHONE: _____DATE OF LAST PHYSICAL: _____ PRIMARY INSURANCE: _____

_____ POLICY NO: _____ PHONE: _____ DENTAL

INSURANCE: _____ POLICY NO: _____ PHONE: _____

PAST HISTORY AND ALLERGIES:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING ILLNESSES?

___Anemia

____Asthma

____Chicken Pox

____Epilepsy

____Bleeding Tendency

____Mumps

____Diabetes

____Hay Fever

____Measles

____Migraine Headache

____Whooping Cough

____Allergies

_____

_____

NOTE: PLEASE COMPLETE INFORMATION ON PAGE 1 AND 2