Grants Pass Adventist School
Home School Enrollment Form
2014-15

Student Information:

Last Name:	First Name:	Middle initial:	Goes By:	Current Grade:
Street Address:	City:		State:	Zip:
Home Phone:	Home Church:			
Birth Date:	Age:	Place of Birth:		Gender: (circle) Male / Female

Family Information:

Student Lives With: (circle all that apply)	Father	Mother	Guardian
	Step-Father	Step-Mother	Grandparent
Parents/Guardian Names:	Mr. Mrs. Ms. (please circle)	Religious Affiliation: Baptized: Yes No	
	Mr. Mrs. Ms. (please circle)	Religious Affiliation: Baptized: Yes No	
Cell phone:	Email address:		

Student Pledge

Because I have chosen to participate in Grants Pass Adventist School homeschool program I will:

- **S**how God's love to others
- **P**erform my best in school
- **I**ntegrate the gifts God has given me to bless others
- **R**espect the people God has placed over me
- **I**nitiate caring for the property around me
- **T**ake care of any problems I cause

Date _____ Signed _____

Parent Contract

Understanding that the school has created a community to help students excel Spiritually, Academically, Physically and Emotionally, I agree to be a partner with the school by:

- **G**oing directly to the teacher with questions or concerns
- **P**roviding adequate sleep and nutrition for my child
- **S**upporting the school's vision and policies
- **D**onating my time as needed to help my child succeed
- **A**ccepting financial responsibility

Date _____ Signed _____

Please complete both sides of this form.

Grants Pass Adventist School
Medical Consent Form
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Emergency Information:

Person to be notified in an emergency other than parent(s):	Relationship:	Phone #:
Physician's Name:	Phone #:	

Medical History:

_____ diabetes

_____ heart problems

_____ asthma

_____ severe headaches

_____ other, _____

Any known allergies? _____

Does this student take any medication(s) regularly? Please specify.

_____

Physical deficiencies: hearing _____ sight _____ speech _____

MEDICAL CONSENT

In case of accident or serious illness, if the school is unable to contact me, I hereby authorize the school to take my child to the physician or dentist indicated above. If it is impossible to contact this physician or dentist, the school may take my child to a hospital authorized by the Board of Health, or to the relative or neighbor listed above.

Date _____ Signed _____

Parent or Guardian