LELAND CHRISTIAN ACADEMY

A MINISTRY OF FBC LELAND

PRESCHOOL APPLICATION
517 VILLAGE ROAD NE
LELAND NC 28451
910-371-0688
WWW.LELANDCHRISTIANACADEMY.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 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:

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	
5 Days: FT	5 Days: FT	5 Days: FT 5 Days: ½ M-W-F: FT	5 Days: FT 5 Days: ½ M-W-F: FT	5 Days: FT 5 Days: ½	**Please indicate the program for which you are applying**

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 <u>only be released</u> 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:**