



Jubilee Christian Academy
a house where God lives and kids learn

***Student Application
Package***

Has this student ever been suspended or dismissed from school? If yes, please explain.

Justice Involvement

Has this student ever been arrested? Yes No If yes, please explain circumstances on the back side of this page.

Is this student now or has this student ever been under the custody of Juvenile and/or Court Authorities/Decrees? Yes No If yes, please explain circumstances on the back of this page.

Sign Out Authorization
(Other than parents)

Please list the names of all persons who are authorized to sign your student out from school. Students will not be allowed to sign out with any other persons without specific permission.

Name	Relationship	Phone

Parent's Questionnaire

Please explain why you would like to enroll your student in Jubilee Christian Academy.

What events can you identify as crucial in your child's life thus far?

Please describe your child's greatest needs in each of the following areas:

Spiritual _____

Academic _____

Social _____

Behavioral _____

Has your child been diagnosed with a learning difference? _____ If so, please explain.

Is your child currently taking any medication? _____

List all medications

Please describe how you handle disciplinary issues in the home. _____

How will you respond to any disciplinary issues with your child at JCA?

Have you have been involved in your child's school, homework, and classroom?

As a parent, how would you like to become involved with Jubilee Christian Academy?

Parent's Spiritual Foundation

Do you have a personal relationship with Jesus? Yes No

Have you been water baptized? Yes No

Have you been baptized in the Holy Spirit? Yes No

I understand that Jubilee Christian Academy teaches the necessity of each. Initial: _____

Church Affiliation

Denomination

Pastor

Years Attended

Is the entire family active in the above listed church?

Yes No

If yes, please describe activities in which involved.

Student's Spiritual Foundation

Has this student accepted Jesus Christ as their Lord and Savior? Yes No

If yes, when? _____

Has this student been water baptized? Yes No If yes, when? _____

Has this student received the baptism of the Holy Spirit? Yes No If yes, when? _____



Applicant's Pastoral Recommendation

Applicant and or Parent: Please provide your name and address on the lines below and request that your pastor complete this form and return it to Jubilee Christian Academy, 5910 North W Street, Pensacola, FL 32505 or fax it to 850-494-2900.

Student Name _____
 Last Name _____ First Name _____ MI _____
 Address _____
 Street _____ City _____ State _____ Zip _____

I hereby waive the right to inspect this confidential recommendation which is part of my admissions file.

 Signature of Applicant (or Parent/Guardian) _____ Date _____

Dear Pastor: The student listed above is applying for admission to Jubilee Christian Academy. Your recommendation is an important consideration in our admissions process. Please complete this form as candidly as possible. All information is confidential. Please use the reverse of this form to make any additional comments. Thank you for your assistance.

1. How long have you known the applicant? _____
2. How well do you know the applicant?
 Just by name and sight
 Casually, have had few personal contacts
 Fairly well, have had a number of personal chats
 Have a close pastoral friendship
3. To the best of your knowledge, has this student made a personal commitment to Jesus Christ?
 Yes No I do not know
4. To what extent is this student involved in activities at your church?
 Irregular in attendance/involvement
 Attends regularly
 Attends regularly and is firmly committed and actively involved
5. How would you rate this student's influence on other people?
 Spiritual Values Positive Neutral Negative I do not know
 Leadership Positive Neutral Negative I do not know
6. I recommend this student:
 without reservation with reservations I do not recommend
 Explain _____

Pastor's Name _____ Pastor's Signature _____
 Church Address _____ Date _____
 City _____ State _____ Zip _____ Phone _____



Jubilee Christian Academy
Authorization for Emergency Care to a Minor
Reference: Florida Statutes 1991, Chapter 234:46

Student Name _____
Last Name First Name MI Grade
Address _____
Street City State Zip
Phone and e-mail _____

Does this child have any allergies or medications, have physical limitations, or any other special or medical needs? If yes, please explain.

In case of emergency illness or accident, the child is given First-Aid and the parents are notified. If the parents or the child's doctor cannot be located, an ambulance may be summoned and/or the child may be taken to the emergency room. **Jubilee Christian Academy does not assume responsibility for hospital, doctor, or ambulance fees.**

Hospital or Emergency Room of choice _____
Health Insurance _____ Policy # _____

I/we the undersigned parent(s) or legal guardian(s) of the minor listed above do hereby authorize any x-ray examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the State of Florida and hospital service that may be rendered to said minor under the general, specific or special consent of an acting agent of Jubilee Christian Academy, the temporary custodian of a minor, whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the State of Florida. I/we authorize the physician or dentist to his/her discretion in authorizing the disposal of any severed tissues or member. It is understood that this consent is given to encourage those persons who have temporary custody of the minor, and said physician or dentist, to exercise their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment. This consent shall remain in effect for the duration of a student's enrollment at Jubilee Christian Academy unless sooner revoked in writing, delivered to said physician or dentist, or to said person entrusted with the custody, care, and control of said minor.

Signature of Parent(s) _____
and/or Guardian _____

Signature of Witness _____ Date _____

**MEDICATION PROTOCOL AT SCHOOL
PARENT RESPONSIBILITIES**

Prescription Medication

1. An Authorization for Administration of Prescription Medication form must be filled out by the physician, **and** signed by the parent (forms are at the physician's office.)
2. A separate authorization form must be filled out for **each** medication administered.
3. Changes in medication require a **new** authorization form signed by the physician and parent.
4. Medication must be in the **original** pharmacy-labeled container.
5. No more than a 30-day supply of medication may be accepted.
6. A responsible adult must deliver and pick up the medications in the school clinic.
7. Communicate any medication changes **directly** to designated JCA office staff, including discontinued medications.
8. If your child is authorized to receive an early morning medication at school, do not give this does at home.
9. When medication is discontinued or school year ends, pick up all unused medication within one week. Unclaimed medications will be discarded.

Non-Prescription Medication

1. An Authorization for Administration of Non-Prescription Medication form must be filled out and signed by the parent (forms are in the JCA office). Based on the Escambia County School District's policy for over-the-counter (OTC) medicines, **Acetaminophen (e.g. Tylenol) is the only OTC pain reliever** administered in schools with a completed and signed Authorization for Non-Prescription Medication form. Any other OTC pain reliever **requires** a completed and signed Authorization for Prescription Medication Administration form (as described above).
2. A separate authorization form must be completed for **each** medication administered.
3. Non-prescription medication must be in the original, preferable, **small or travel size** container with an intact manufacturer's label.
4. The medication dosage **must be age-appropriate** as stated on the label.
5. Communicate any medication changes **directly** to designated JCA office staff, including discontinued medications.
6. A responsible adult must deliver and pick up the medications in the school office.
7. When medication is discontinued or school year ends, pick up all unused medication within one week. Unclaimed medications will be discarded.

Your signature below acknowledges that you have read and agree to abide by the above-stated policy.

Parent/Guardian Signature

Date

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY HEALTH SERVICES J.E. Hall Center 30 E. Texar Drive Pensacola, FL 32503 Phone: 469-5456	AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION
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THIS FORM IS VOID IF ALTERED IN ANY WAY.

INSTRUCTIONS: Each of the three sections must be completed by parent/guardian. Please return the completed form to the school health room/office.

I. STUDENT INFORMATION (To Be Completed by Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Medicaid #	Grade/Homeroom Teacher
Parent/Guardian		Address	
Home Phone	Work Phone	Other Phone (Cellular, Beeper, etc)	

II. ACTION PLAN (To Be Completed by Parent/Guardian). Please complete all spaces.

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20__ - 20__ OR EARLIER STOP DATE:

MEDICATION: _____

GENERIC NAME (IF USED) _____

DOSAGE AMOUNT: _____ Medication dosage must be age appropriate within recommendations on manufacturer's label. Use label for recommended time schedule when needed at school for the following conditions or symptoms. _____

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I request the designated school personnel to assist my child in the administration of the above described medication. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school district, its personnel, or agents, including Escambia County Health Department personnel, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonable prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, which occurs first.

Parent/Guardian Signature: _____ Date: _____

Non-prescription medication requests must be renewed by the parent/guardian and release signed by the parent/guardian annually. Each medication, or any change in medication, requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired.

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