

The Lighthouse Christian Academy



Returning Student Application
2009-10 School Year

Thank you for choosing the Lighthouse Christian Academy!

We look forward to the continued opportunity to partner with you in the Christ-centered education of your child.

The goals of the Lighthouse Christian Academy are as follows:

1. That every individual has a personal relationship with Jesus Christ and that they develop a love for the Lord. (Matthew 28:19-20: “Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything I have commanded you.”)
2. That every individual be a disciple of Jesus Christ, thoroughly equipped for every good work (2 Timothy 3:17), so that they may, "go into all the world and preach the gospel" (Mark 16:15). This is accomplished by consistent attendance of church services and involvement in church ministries.
3. That every individual grow in Christian character and scholarship so that each individual's "light" will shine to glorify the Lord (Matthew 5:16).
4. That the home, the church and the school work together to accomplish these goals.
5. That the home agrees with the doctrinal statement of the Lighthouse Church and supports the vision of the church and school, which is world evangelism, church planting and discipleship.

Sincerely,

Richard Cornett
Principal



RETURNING STUDENT REGISTRATION FORM

PLEASE PRINT. MAKE SURE ALL INFORMATION ON BOTH PAGES IS COMPLETE. PLEASE INFORM US IMMEDIATELY IF ANY OF THE FOLLOWING INFORMATION CHANGES DURING THE COURSE OF THE SCHOOL YEAR.

Student's Full Legal Name: _____ Home Phone: _____

Student's E-mail Address: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth date ___/___/___ Birth place: _____ Social Security Number ___-___-___

Student's legal guardian(s) _____

Father's Name: _____ Father's Cell Phone: _____

Employer: _____ Father's Work Phone: _____

Father's E-mail Address: _____

Mother's Name: _____ Mother's Cell Phone: _____

Employer: _____ Mother's Work Phone: _____

Mother's E-mail Address: _____

Marital status of parents: _____ Child lives with: _____

Name of person responsible for tuition: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ Phone: _____

I will be responsible to pay the tuition of \$550 per month for 10 months for _____.

Student Name

Signed: _____ Date: _____

[] RELEASE OF LIABILITY

My child has permission to leave campus, unsupervised, during break and lunch times. I assume full responsibility for my child after the official end of the school day.

Signed: _____ **Date:** _____

Parent or Legal Guardian



NO STUDENT IS ADMITTED WITHOUT THE FOLLOWING:

TB skin test - All pupils entering an L.A. county school **for the first time** are required to present evidence of a tuberculosis skin test. A TB skin test (Mantoux) is required each year.

Written Immunization Record

Students entering a California school for the first time on or after March 5, 1986 must provide a **written immunization record** or receipt of each required vaccine dose. This record must show the date (at least month and year) of each required dose. Newly entering pupils who currently need additional vaccinations or who lack a written record of having received doses are no longer allowed a ten-school-day period of conditional attendance while awaiting receipt of immunization(s) or while producing a written immunization record. All required immunizations must be complete in order to be admitted to school.

Doctor's Physical Examination - All students entering school must have a complete doctor's physical examination within one year of admission. You may use the form in the Health Packet. This form must be filled out and signed by the physician.

AUTHORIZATION TO TREAT MINOR:

I/(we), the undersigned parent, parents or legal guardian(s) of _____, a minor, do hereby understand, consent and authorize The Lighthouse Christian Academy or The Lighthouse Church to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary medical, surgical and dental care, in case I am not immediately available. I/we also authorize and consent to any X-ray examination, anesthetic, medical or surgical treatment rendered by any member of the Medical Practice Act, or a Dentist licensed under the provisions of the Dental Practice Act on the staff of any acute general hospital holding a current license to operate a hospital from the State in which that hospital is located. It is further understood that this authorization is given in advance of any specific diagnostic treatment or hospital care deemed advisable in their best judgment. It is understood that efforts shall be made to contact the undersigned prior to rendering treatment to the student, but that none of the above treatment will be withheld if the undersigned cannot be reached. I/we understand that medical treatment authorized by the Lighthouse is my financial responsibility. Furthermore, if my child(ren) are injured while at the Lighthouse or off the premises, it is my complete responsibility. I/we understand that my child(ren) has clearance to participate in physical education class and or any other school sports; [or] state the reason(s) your child(ren) cannot participate in physical education by attaching a letter from their physician to this form. An excuse note must be sent by a medical provider listing how long the inability to participate applies. If your child has any food or drug allergies, or needs medication during school hours, please notify the office or teacher prior to the first day of school.

Signed:(X) _____
Legal Parent or Guardian

Date: _____

MEDICAL AND HEALTH INFORMATION: (All information must be complete. Please print.)

Physician Name _____ Phone: _____

Health Insurance Name: _____ Phone: _____

Policy Number: _____

Subscriber Name : _____ Relationship: _____



CREDIT/DEBIT CARD PAYMENT AUTHORIZATION

PLEASE PRINT. PLEASE INFORM US IMMEDIATELY IF ANY OF THE FOLLOWING INFORMATION CHANGES DURING THE COURSE OF THE SCHOOL YEAR.

I, _____, authorize the Lighthouse Christian Academy to charge my credit/debit card **\$550 per month on the first day of each month** for 10 months (*September 2009 - June 2010*) for the **tuition** of _____ (*Student Name*).

I authorize the Lighthouse Christian Academy to charge my credit/debit card **\$500 on July 1, 2009** for the **registration fee** for the 2009-2010 school year. I understand that this registration fee is NON-REFUNDABLE.

I authorize the Lighthouse Christian Academy to charge my credit/debit card **\$250 on August 1, 2009** for the **textbook fee** for the 2009-2010 school year. I understand that this textbook fee is NON-REFUNDABLE.

Card type (Check one.): Visa Mastercard Discover

Card Holder Name: _____

Credit Card Number: _____

Expiration Date: _____

Three-digit Security Code: _____

Cardholder Billing Address: _____

Cardholder Billing Phone Number: _____

Cardholder Signature

Date





The Lighthouse Christian Academy

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www.thelighthousechristianacademy.org

Church Attendance Form

Dear Pastor,

_____ (Parents' Names), and their child

_____ (Student's Name)

have applied to the Lighthouse Christian Academy. One of our requirements is that each student attends a Christian church on a weekly basis. The student's parents have indicated that their son/daughter attends your church. Please complete the form below and return it either by mail to the address above or to the parents to return to us.

Thank you for your time.

Richard Cornett
Principal

The above named parents/children attend service at:

Name of Church

Church Address

How long has the applicant attended your church? _____

How often does the applicant attend your church?

___ weekly ___ monthly ___ holidays only ___ rarely ___ does not attend

Pastor's Name: _____ Phone Number: _____

Comments:

Pastor's Signature: _____



SPORTS PERMISSION FORM

I give permission for my son/daughter _____ to participate
(Student Name)
in the school sports _____.
(Name of Sports)

I have submitted to the Lighthouse Christian Academy a doctor's physical examination form and a copy of my child's immunization records.

Parent/Guardian Signature

Date

Print Name



Preparticipation Physical Examination Form

(Please type or print)

Student's Name _____ Birth Date _____ Sex _____ Grade _____

Last First Middle

City _____ School _____ Place of Birth _____

Student's Address _____

Street City Zip Telephone

Parent(s) or Guardian(s) Name _____

Address (if different than student) _____

Street City Zip Telephone

Family Physician's Name, Address, Telephone _____

History

This section is to be carefully completed by the student and his/her parent(s) or legal guardian(s) before participation in interscholastic athletics in order to help detect possible risks.

Explain "YES" answers below. Circle questions you don't know the answer to.

	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last checkup or sports physical? Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight? Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you cough, wheeze or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any problems with your eyes or vision? Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever had a sprain, strain or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? <i>If yes, check the appropriate box and explain below.</i>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a rash or hives develop during or after exercise? Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Is there a family history of heart problems in a close relative younger than age 50 (examples are enlarged heart, cardiomyopathy, long QT interval, abnormal EKG, abnormal heart rhythm)? Have you had a severe heart infection (for example, myocarditis or pericarditis)? Is there a family history of Marfan's Syndrome? Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head <input type="checkbox"/> Upper Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Finger <input type="checkbox"/> Shin/ankle <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Hip <input type="checkbox"/> Ankle <input type="checkbox"/> Chest <input type="checkbox"/> Wrist <input type="checkbox"/> Thigh <input type="checkbox"/> Foot <input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had a severe viral infection within the last month (for example, mononucleosis)?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs or feet? Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	17. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____	<input type="checkbox"/>	<input type="checkbox"/>
			18. FEMALES ONLY When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____		
			19. ALL PARTICIPANTS Explain "Yes" answers here: _____ _____ _____ _____ _____		

NOTE: CONSENT AND HIPAA RELEASE FORMS THAT MUST BE SIGNED BY BOTH THE PARENT AND THE STUDENT ARE ON A SEPARATE SHEET.

NOTE: History and All Consent Forms Must be Completed Prior to Physical Examination

Modified from the form approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.



Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials*
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MEDICAL

Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

Clearance

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____
 Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

 Physician's Name and Address (stamp or print)

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

 Examiner's Signature

 Date

 Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination

