Flint Academy
New Student Packet
Check List

Please fill out and return the following:

_____ Application

_____ Release of Records Request

_____ Media/Field Trip Authorization

_____ Off Campus Lunch (Upper School only)

_____ Pick Up Form

_____ Handbook Statement

_____ Emergency Medical Authorization

_____ OTC Medication

_____ Medication Supervision (fill out only if medication needs to be given at school)

_____ Current Immunization Record

Flint Academy

APPLICATION for ENROLLMENT

School Year: _____-_____

STUDENT INFORMATION Date: _____

Student's Name:

_____
(last) (first) (middle)

Student's Address:

_____

City: _____ State:_____ Zip _____

Birth Date: _____ ☐Male ☐Female

Hispanic ☐ Asian ☐ Am. Indian or Alaskan Native ☐ Black or African American ☐

White ☐ Native Hawaiian or other Pacific Island ☐

FAMILY INFORMATION

Who does the child live with (circle one): Mother Father Both Parents Other

Other:_____

Mother/Legal Guardian:

Name:

_____
(last) (first) (middle)

Home Address (If different from child's):

_____

Home Phone: _____Cell Phone: _____

E-Mail Address:

_____

Employer and Address:

_____

Business Phone: _____Occupation: _____

Father/Legal Guardian:

Name:

_____
(last) (first) (middle)

Home Address (If different from child's):

_____

Home Phone: _____Cell Phone: _____

E-Mail Address: _____

Employer and Address: _____

Business Phone: _____Occupation: _____

Siblings Names & Ages:

_____

Grade Level your child last completed or if in mid-year, grade your child is in now:

Completed: _____ Currently Enrolled In: _____

Special Learning Needs/Health Needs: (explain in detail)

List all other schools your child has attended (school name, city, and dates):

How did you learn about The Flint Academy?

What influenced you to enroll your child in The Flint Academy?

What have you found lacking in other educational settings?

What have you found that you liked in other educational settings?

What is important to you about an educational setting for your child?

Describe your child's temperament, interests, and special attributes so that teachers can better work with him/her:

Flint Academy
2111 Roosevelt Dr.
Arlington, TX 76013
www.FlintAcademy.com
817-277-0620

Flint Academy

Authorization for Release of School Records

Name of Student: _____ **Date of Birth:** _____

Date: _____

I give my permission for the transfer of copies of my child's records from:

School: _____

Address: _____

_____

Phone: _____ Fax: _____

to: Flint Academy
2111 Roosevelt Drive
Arlington, Texas 76013
817-277-0620
kim.walker@flintacademy.com

The record should include copies of the following:

1. Transcripts of grades, progress reports, and teacher reports.
2. Results of all standardized tests.
3. Behavioral incident reports, behavioral plan, academic and psychological testing, if applicable.
4. Medical data/Immunizations
5. Other information maintained in student's permanent record pertinent to developing an optimal academic and social program for the student.

Parent's Signature

_____

Flint Authorized Signature

_____

Date: _____

Flint Academy
Authorizations

School Year: _____-_____

Student Name: _____ Grade: _____

Media

Each year, Flint Academy requests that each parent or guardian return a permission slip regarding use of their child's name or image for media purposes. Media may be in the form of a public newspaper or Flint Academy web pages. Permission must be received from parents or guardians in order for a student to have their name and/or picture posted in any of these media.

Relative to my child, I hereby give permission to:

Allow a recognizable image, still or video, in a local newspaper or news broadcast in connection with an event, award, or activity at Flint Academy. Yes No

Incorporate a recognizable digitized image, still or video, on our school Internet web page, along with their first and last name, to publicize an event, award, or activity at Flint Academy. Yes No

Incorporate a recognizable digitized image, still or video, on our school's Social Media page, along with their first and last name, to publicize an event, award, or activity at Flint Academy. Yes No

Use my child's first and last name on our school Internet web page in connection with student work, list of awards, or reporting of an event or activity at Flint Academy. Yes No

Field Trip

My child has my permission to participate in all field trips and off campus activities that pertain to his or her class or to Flint Academy as a whole. I understand that such trips and activities may require the use of transportation. If transportation is used, all the vehicles and drivers will be approved by the Director of Flint Academy. I understand that if my child should be restricted from participating in any field trip or off campus activity, I must notify their teacher in writing prior to the planned event.

Inclement Weather Contact Information

Number to contact for notification of school closing or early dismissal: _____

Parent Signature: _____ Date: _____

Off Campus Lunch
(Upper School Only)

School Year: _____-_____

Upper school students may go off campus any day of the week for lunch with written permission from a parent or legal guardian. Students may go to Green's, Quik Stop, or Prespa's or other places within a one block radius of the school.

My child can do the following during their lunch break:

Yes No My child may walk next door to Green's Produce.

Yes No My child may walk off campus for lunch.

Yes No My child may drive off campus for lunch.

Yes No My child may drive other students off campus for lunch.

Yes No My child may ride with another student off campus for lunch.

Yes No My child may ride with a teacher/staff off campus for lunch.

Student Name: _____

Age: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Flint Academy
School Year _____ - _____

Student Pick Up Authorization Form

In an effort to protect our students, we are asking that you let us know in advance who has your permission, other than you, to pick up your child. You may pre-authorize individuals by listing them below. Please let these individuals know that they may be asked to show photo identification if a staff member is unfamiliar with them. Anyone coming to pick up your child who is not on the list will not be allowed to leave with your child unless we have received a prior, written notification from the custodial parents/guardians.

Student Name: _____
Last First Middle Initial

Custodial Parents/Guardians: _____ Phone: _____

AUTHORIZED ADULT TO PICK UP STUDENT

Name	*Phone Number*	*Relationship to Student*
Name	*Phone Number*	*Relationship to Student*
Name	*Phone Number*	*Relationship to Student*
Name	*Phone Number*	*Relationship to Student*

Please list any adults who are *NOT* authorized to pick up your child: _____

_____

Parents/Legal Guardians Authorization.

The information above is correct, and I/we hereby give permission for my child to be picked up from the listed individuals. I /we understand that my child will not be released to any individual that is not listed on this form.

_____
Parents / Guardians Printed Name

_____
Parents / Guardians Signature Date

STUDENT/PARENT STATEMENT OF COOPERATION

School Year: _____-_____

I have read the Student Handbook. It is my personal desire and choice to attend this school. Thus I will voluntarily observe the principles, policies, and guidelines set forth in this handbook. I will conscientiously seek to develop that pattern of life that will honor the Lord Jesus Christ in my personal, family, school and social relationships.

Student Name: _____

Grade: _____ Age: _____

Please note: If a student is living with more than one parent/guardian, each parent/guardian needs to sign a copy of the following statement. (The school will retain a copy of this signed documentation.)
Statement: I hereby acknowledge that I have read the Student Handbook and discussed it with my child and agree to fully support the school policies outlined.

_____ _____
Signature of Parent or Guardian **Date**

_____ _____
Signature of Student **Date**

***After the student and parents have carefully read the contents of this handbook, please sign and return the Student/Parent Statement of Cooperation to the school office. Returning this signed statement is required as part of the enrollment or re-enrollment procedure.**

Flint Academy
Emergency Medical Authorization Form

School Year: _____-_____

Please fill out the form below and return it to your child's school. It is very important that this form be filled out completely.

Student's Name: _____ Birth Date: _____ Age: _____ Grade: _____

Address: _____ City: _____ State: ____ Zip: _____

Home #: _____ Student's Cell #: _____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Parent or Guardian

Mother's Name: _____ Email: _____

Home #: _____ Cell #: _____ Work #: _____

Father's Name: _____ Email: _____

Home #: _____ Cell #: _____ Work #: _____

Emergency Contacts: Please list as least two local contacts we can contact in case of an emergency if we are unable to contact you first.

Contact Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

Contact Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning my child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

Allergies: _____

Current Medications: _____

Medical Conditions: _____

Date: _____ Signature of Parent/Guardian: _____

Flint Academy
Authorization for Treatment and Over-the-Counter Medication

School Year: _____-_____

Name of Student: _____ DOB: _____ Age: _____ Grade: _____

Over-The-Counter (OTC) Medication

Section I: THE FOLLOWING MEDICINE IS STOCKED IN THE NURSE'S OFFICE. PLEASE CIRCLE YES OR NO TO GIVE YOUR PERMISSION FOR YOUR CHILD TO HAVE ANY OF THE FOLLOWING. DOSAGE IS BASED ON WEIGHT. MEDICINE DOSES OTHER THAN MANUFACTURER'S RECOMMENDATIONS REQUIRE A SIGNED ORDER FROM THE STUDENT'S PHYSICIAN.

Weight: _____

Circle yes or no:			DOSE
yes	no	Tums (or generic equivalent)	1 2 Other: ____
yes	no	Pepto Bismol chewable tabs	1 2 Other:____
yes	no	Cough Drops	
yes	no	Ibuprofen (Motrin/Advil) 200 mg tabs	1 2 Other: ____
yes	no	Ibuprofen (Motrin/Advil) liquid 100 mg/5ml	Dose is based on weight
yes	no	Ibuprofen (Motrin/Advil) 100mg chewable tabs	Dose is based on weight
yes	no	Acetaminophen (Tylenol) 500 mg	1 2 Other: ____
yes	no	Acetaminophen (Tylenol) liquid 160mg/5ml	Dose is based on weight
yes	no	Acetaminophen (Tylenol) 160mg chewable tabs	Dose is based on weight
yes	no	Triple Antibiotic cream - topical	
yes	no	Hydrocortisone - topical anti-itch	
yes	no	Benedryl cream - topical anti-itch	
yes	no	Calamine Lotion - topical anti-itch	
yes	no	Sting-Kill Swabs (topical anesthetic for stings)	
yes	no	Normal Saline eye drops	
yes	no	Benadryl for allergic reactions 12.5 mg _____ 25 mg _____ other dosage _____	

PLEASE NOTE:
WE DO NOT GIVE OTC MEDICINES SPECIFIC TO CONGESTION, SINUSES OR SEASONAL ALLERGIES

OTC Medications Other: Parent must provide in original packaging

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Section II: Authorization and Consent for Medical Treatment and Over-the-Counter Medication

I authorize The Flint Academy, through its nurse or other qualified person, to administer first aid or other minor medical treatment including over-the-counter medication as shall be deemed best under the circumstances to my child. I consent for my child to receive such treatment during school hours and at school activities, including all school sponsored programs. I understand the school will attempt to notify parents/emergency contact in the event of an emergency requiring immediate medical care for my child. If the school is unable to notify me, I give permission for my child to be treated by a fully qualified physician at the nearest emergency clinic. I acknowledge that it is my responsibility to keep my child's records (phone numbers, work location, emergency contact, health status and immunization records) current. I also understand that neither medical nor accident insurance is provided by The Flint Academy, and that the responsibility for providing such coverage rests with me as parent/guardian for my child.

_____ _____ _____
Parent/Guardian Signature Date Phone

Flint Academy
Authorization for Medication Supervision/Assistance
(Only for medication that needs to be taken at school)

School Year: _____-_____

STUDENT'S NAME: _____ DOB: _____ Grade: _____

ORDERING PHYSICIAN'S NAME: _____ Phone #: _____

MEDICATION _____ Dosage _____

to be taken AT SCHOOL @ _____o'clock OR *Intermittent medicines only* As needed_____ Every_____hours

This request is valid from (dates) _____ to _____

This medication is for _____

Any side effects your child might have experienced before:

_____

_____

Special instructions:

_____

NOTE: PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL CONTAINER FROM THE PHARMACY. ONLY THE INSTRUCTIONS FOR DOSAGE AND TIMES FOR ADMINISTRATION WRITTEN ABOVE OR RECEIVED FROM THE PHYSICIAN WILL BE FOLLOWED. OTC MEDICATION WILL BE GIVEN FOR UP TO ONE SCHOOL WEEK ONLY UNLESS WRITTEN INSTRUCTIONS FROM PHYSICIAN, WITH STATED LENGTH OF TIME TO BE TAKEN IS RECEIVED.

I authorize the personnel of The Flint Academy to assist my child in taking medication. This includes setting up individually labeled pillboxes for daily medication doses. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse The Flint Academy, the individual members, agents, employees and representatives thereof, from and against any claim, which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administration/supervision/assistance of this medication.

Parent/Guardian Signature Date

Daytime Telephone Number: _____

. . . . . .

Office use only:

_____

_____