Whitehall Christian School

3950 Mechanicsville Rd., Whitehall, PA 18052 Phone (610) 799-2341

RE-ENROLLMENT FORM 2020-2021

STUDENT INFORMATION: LAST NAME	FIRST NAME	MIDDLE NAME

STUDENT HOME ADDRESS:

DATE OF BIRTH:	**Resident School District:**

Please complete any CHANGES to the following information:

FAMILY INFORMATION	**FATHER**	**MOTHER**	**GUARDIAN**
Full Name			
US Citizen (**Check One**)	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Marital Status			
Religious Affiliation			
Occupation			
Employer			
Employer Address			
Home Address (If different than student)			
Home Phone Number			
Cell Phone Number			
E-mail Address			

Student Lives With (Check one): **Both Parents** ☐ **Father** ☐ **Mother** ☐ **Guardian** ☐

Other Children Living in the Household (List oldest to youngest)

Name:
Name:
Name:

Emergency Contacts

List Emergency Contacts ***other than Parent/Guardian***

Contacts Name	Phone Number	Relationship to Student	Authorized to pick up child
1.			Yes ☐ No ☐
2.			Yes ☐ No ☐
3.			Yes ☐ No ☐
4.			Yes ☐ No ☐

Family Physician's Name: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Continuing Consent to Treatment and Authorization to Release Information in Cases of Emergency

In case of medical emergency, I, the undersigned, will expect Whitehall Christian School to contact me. If I cannot be reached, I authorize the school to seek medical attention for my child. I understand that my preferred physician may not be the facility available for the immediate emergency care of my child. Consent is hereby given for transport by a school representative, EMS personnel and/or hospital emergency staff to seek treatment from licensed medical staff as deemed necessary by their professional judgement. The school may deliver my child to members on the emergency contact list above.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or Whitehall Christian School.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the student accident insurance carrier or its representative any and all information with respect to any illness, medical history, consultation, X-ray, or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

Parent's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

Consent to Field Trips

I realize when I register my child at WCS, I am giving permission for my child to attend field trips, unless I have indicated otherwise in writing, expressing my reason(s). All field trips are regarded as school days; therefore, any absences will be handled in the manner as outlined in the School Handbook.

Parent's Signature: _____