Lake Nelson Sda School Application

"Empowering Students through Christian Education"

Lake Nelson Seventh-Day Adventist School

" Empowering Students with Christian Education since 1959 "

555 South Randolphville Road ✦ Piscataway, NJ 08854

☎: (732) 981-0626 Fax: (732) 981-0770

OFFICE USE ONLY: STUDENT ID # ______________

STUDENT ADMISSION APPLICATION

Student's First Name:	Middle Name:	Last Name:
Address:	City/State/Zip:	Home Phone:
Date of Birth:	Gender: ( )Female ( ) Male	Grade Entering:
Place of Birth (City/State/Country)	Is Student a Baptized Member of the SDA church? ( )Yes ( ) No If yes, Date:______________________	
SS#:	Country of Citizenship:	Enrollment Date:

FAMILY INFORMATION

Marital Status of Natural Parents: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MOTHER/GUARDIAN	FATHER/GUARDIAN
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Day Time Emergency Phone :	Day Time Emergency Phone:
E-mail:	E-mail :
Occupation:	Occupation:
Work Phone:	Work Phone:
Church Membership:	Church Membership:

EMERGENCY/AUTHORIZED PICK UP CONTACT INFORMATION

Name	Relationship	Home Phone#	Cell#	Work Phone #

I hereby submit this application for admission of my child to Lake Nelson SDA School and I will support school regulations and to help my child observe them. (Please see LNS Handbook) I understand my child is not enrolled or guaranteed placement, until accepted by the admissions committee.

______________________________ ______________________

Parent/Guardian Signature Date

Lake Nelson Seventh-Day Adventist School

CONSENT TO TREATMENT FORM

We, the undersigned parents or guardian of ____

Name of Student or Member

A minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or Treatment and hospital service that may be rendered to said minor under the general or special Instructions of said physician listed below or any physician the school or Organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the Doctor listed below before any other physician is called by the school or other organization.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize ***Lake Nelson Seventh-Day Adventist School,***

Name of organization into whose Custody Minor is entrusted

or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the Physician named above or to the school or organization entrusted with the custody said minor.

The above named Student

☐ **is**

☐ **is not**

covered by Health Insurance ____

Policy # ____

Physician Name____ ☎: Phone No. ____________________

Special Medical Needs (Allergies, Medicines, etc)____

Hospital preferred for Treatment:____

____

DATE

FATHER: ________________________________

MOTHER:________________________________

LEGAL GUARDIAN:________________________

Lake Nelson Seventh-Day Adventist School

555 South Randolphville Road
Piscataway, NJ 08854
Tel: 732.981.0626 / Fax: 732.981.0770

Payment Agreement 2015-2016

To be completed by the party accepting Financial Responsibility:

Student's Name:____

Parent / Legal Guardian: ____

Current Address: ____

Home Phone: _______________________ **Work Phone:** ________________________

Fax: ____________________________ **Cell Phone:** _________________________

SS# of Parent/Guardian: _______--______--________

I understand and agree to accept full financial responsibility for:

- The full and timely payment of tuition, to be collected in ten monthly installments.
- All associated charges incurred by my child while in attendance (i.e. registration fee, late fees and aftercare participation).
- Maintaining an account balance that will remain current with my billing statement. In the event that my child's account should become delinquent, consisting of open invoices items which exceed 45 days, I understand that my child will receive a financial suspension until the account balance is resolved.
- Obtaining outside financial assistance (i.e. church/agency/family assistance). I will be held responsible for all unpaid obligations, including late fees incurred due to delinquent payment from these sources.

____ __________________

Parent / Legal Guardian Date