

# Lake Nelson Adventist Academy



Adventist Education

A JOURNEY TO EXCELLENCE

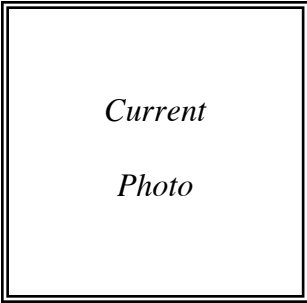
*"Empowering Students through Christian Education"*

555 South Randolphville Road  
Piscataway, NJ 08854  
(732) 981-0626  
Fax: (732) 981-0770  
Elisa Maragoto, Principal



**Adventist Education**  
Lake Nelson Adventist Academy

*"Empowering Through Christian Education since 1959"*  
555 South Randolphville Road - Piscataway, NJ 08854  
(732) 981-0626 Fax: (732) 981-0770



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 Date: _____ Church: _____	
SS#:	Country of Citizenship:	Enrollment Date:

**FAMILY INFORMATION**

Marital Status of Natural Parents:  Single  Married  Separated  Divorced  Widowed

<b>MOTHER/GUARDIAN</b>	<b>FATHER/GUARDIAN</b>
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Day Time Phone# :	Day Time 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 Adventist Academy 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



**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 Adventist Academy,  
**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:



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**Financial Responsibility Agreement 2017-2018**

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



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Lake Nelson Adventist Academy

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## **Transcript Request Form**

*I/We, the undersigned parent(s)/guardian(s) of*

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(Name of Student)

*Do hereby Authorize*

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(Previous – School's Name)

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(School's Address)

---

( City, State, Zip Code)

*To Release –*

- *Transcripts*
- *Test Scores*
- *Immunization, health- A45*
- *Other pertinent records*
- *IEP (If Applicable)*

**Signature:** \_\_\_\_\_

**Parent(s)/Guardian(s)**

### **MAIL RECORDS TO:**

Lake Nelson Adventist Academy  
**Office of Admissions**  
555 South Randolphville Road  
Piscataway, NJ 08854



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## Church Membership Declaration Form

*This is to certify that the Parent/student named below are members:*

**Student's Name:** \_\_\_\_\_

**Parent / Legal Guardian:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Signature of Pastor/Church Clerk/ and or Head Elder**

**Church of Membership:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_