ALL APPLICATIONS ARE SUBJECT TO APPROVAL BY THE SCHOOL BOARD.

Date: _____

SPOKANE VALLEY ADVENTIST SCHOOL

1603 S. Sullivan Road
Spokane Valley, WA 99037

APPLICATION FOR ADMISSION

OFFICE USE ONLY

___ Birth Certificate
___ Physical
___ Immunizations
___ Financial Information
___ Transfer of Records

STUDENT'S FULL LEGAL NAME (Last, First, Middle {no initials})	**GRADE**	**SEX**	**AGE Yr-Mo**	**BIRTHDATE Mo – Day - Yr**	**BIRTHPLACE**	**CHURCH PREFERENCE**	**YEAR BAPTIZED**
		M F					

Names of parents or guardians with whom student is living. **Give full legal names.**	SDA CHURCH MEMBER	HOME PHONE # (Cell phone #)	WORK INFORMATION: CO. Name & Phone #	OCCUPATION	HOME ADDRESS (Include mailing address if different)	TO CALL IN EMERGENCY (Name & Phone #)
FATHER Email Address:	Yes No	Home # Cell #			Zip	Designated Person: Phone #:
MOTHER Email Address:	Yes No	Home # Cell #			Zip	Doctor: Phone #:

Place of Church Membership:

FIELD TRIPS

I give my permission for my child to participate in all planned field trips during the school year. I understand that notification will be given in advance of field trips regarding place, date, time, and cost (if any).

PICTURES & VIDEOS

I also give permission for my child to be included in any school projects using photographs, videotapes, or web page.

_____
Signature of Parent-Guardian

Please list any allergies your child has:

_____

Please list any prescribed medications your child uses:

_____

CONTINUING CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

In case of an emergency, we, the undersigned parents or guardian of _____, 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 _____, M.D., 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 parent(s) and doctor listed above before any other physician is called by the school or 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 Spokane Valley Adventist School or the physician to exercise their best judgment regarding the requirement 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 custody of said minor.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the General Conference Insurance Service, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date: _____ Parent: _____ Guardian: _____

COMMENTS: _____

_____

Parents, do you want family member's names, addresses, and phone numbers to appear in the School Directory? _____ (YES or NO)