

Three Rivers Christian School  
Jr/Sr High (7<sup>th</sup> – 12<sup>th</sup> Grade)  
1209 Minor Road, Kelso, WA 98626 (360)636-1600

Grade: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Student Cell #: \_\_\_\_\_ Student E-mail: \_\_\_\_\_

Goes by: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male [ ] Female [ ]

Church Affiliation: \_\_\_\_\_ Active Participant Yes [ ] No [ ]

*New Student only: Former School Attended:* \_\_\_\_\_

*Address* \_\_\_\_\_

PARENT/STEP-PARENT/GUARDIAN

Last Name: \_\_\_\_\_ Mr/Mrs/Ms First: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_

Relation to Student: \_\_\_\_\_ Lives w/ Student Yes [ ] No [ ] Billing Party Yes [ ] No [ ]

\*\*\*\*\*

Last Name: \_\_\_\_\_ Mr/Mrs/Ms First: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_

Relation to Student: \_\_\_\_\_ Lives w/ Student Yes [ ] No [ ] Billing Party Yes [ ] No [ ]

\*\*\*\*\*

Last Name: \_\_\_\_\_ Mr/Mrs/Ms First: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_

Relation to Student: \_\_\_\_\_ Lives w/ Student Yes [ ] No [ ] Billing Party Yes [ ] No [ ]

Three Rivers Christian School

Emergency Numbers

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ I nclude on Mailing List Yes [ ] No [ ]

\*\*\*\*\*

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ I nclude on Mailing List Yes [ ] No [ ]

\*\*\*\*\*

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ I nclude on Mailing List Yes [ ] No [ ]

\*\*\*\*\*

Grandparents or others you would like to include on the Three Rivers Christian School mailing list (other than those listed above):

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

\*\*\*\*\*

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_

# Three Rivers Christian School

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical conditions, please be specific: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications that your child takes daily: \_\_\_\_\_

\_\_\_\_\_

## Authorization for Emergency Medical Treatment

In the event that (I) (we) cannot be reached at a time of illness or accident, or the emergency is such that time does not permit such contact, (I) (we) the undersigned parent(s) of the child named above, a minor, do hereby authorize Three Rivers Christian School as agent for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medical Practice Act.

It is understood that this authorization is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgement may deem advisable.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

# Three Rivers Christian School

## Financial Agreement

Parent Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Billing Options (Please check one):

Single payment 5% discount (Account must be paid in full by August 15)

10 month payment plan (August 1 - May 1)

12 month payment plan (July 1 - June 1)

Other (please indicate) \_\_\_\_\_ (must be approved by Financial Office)

Failure to indicate a payment choice will automatically result in the 10 month payment plan.

Alternate Billing Party:

Last Name: \_\_\_\_\_ Mr./Mrs./Ms. First: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

I agree that I am responsible for the payment of the account below:

Account Name: \_\_\_\_\_ Student Name: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

