

Three Rivers Christian School

Elementary Campus

2610 Ocean Beach Hwy, Longview, WA 98632 360-423-4510

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

Permission Form

Student Name: _____ Grade: _____

Photograph Release:

I release Three Rivers Christian School to photograph and/or videotape my child while participating in daily activities, and to use photographs and/or videos in photograph displays or other publication showing these daily activities.

Parent Signature: _____ Date: _____

Health Screening:

Lower Columbia College (LCC) will be conducting a free health screening for the students of Three Rivers Christian School. The screenings consist of vision, pediculosis (lice), dental, blood pressure, pulse, hearing, height and weight. Students in 5th and 6th grade will also have a Scoliosis screening.

I give my permission for my child _____ to participate in the Health Screening performed by Lower Columbia College Student Nursing Program.

Parent Signature: _____ Date: _____

Field Trip Authorization:

I give my permission for _____ to participate in all local school sponsored field trips.

Parent Signature: _____ Date: _____

Directory Information:

(Please list information that you would like to have included)

Student Name: _____ Grade: _____

Parent/Guardian: _____

Address: _____

Phone #: _____ Cell #: _____

E-mail: _____

[] Please DO NOT include me in the directory.

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