



Lake Nelson SDA School

555 South Randolphville Road · Piscataway NJ · 08854

732.981.0626

Student Application

STUDENT INFORMATION

Enrollment Date _____

Student ID #

School Use Only

Full Legal Name _____ Gender _____

Date of Birth _____ Age _____ City/State of Birth _____

Last School Attended _____ Grade Entering _____

Church Attending _____ Baptized SDA member Yes
 No

PRIMARY RESIDENCE

Address _____

City _____ State _____ ZIP Code _____

Father's Name _____ Home Ph# _____

Cell # _____ Work # _____ Email _____

Occupation _____ Employer _____

Baptized SDA Member Yes No Church Attending _____

Mother's Name _____ Home Ph _____

Cell # _____ Work # _____ Email _____

Occupation _____ Employer _____

Baptized SDA Member Yes No Church Attending _____

SECONDARY RESIDENCE

Address _____

City _____ State _____ ZIP Code _____

Father's Name _____ Home # _____

Cell # _____ Work # _____ Email _____

Occupation _____ Employer _____

Baptized SDA Member Yes No Church Attending _____

Mother's Name _____ Home # _____

Cell # _____ Work # _____ Email _____

Occupation _____ Employer _____

Baptized SDA Member Yes No Church Attending _____



Lake Nelson SDA 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 _____, M.D., or any physician the school or
Name of Physician

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 above 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 of said minor.

The above named Student

is

is not

covered by Health Insurance _____

Policy # _____

DATE

FATHER: _____

MOTHER: _____

WITNESS

LEGAL GUARDIAN: _____

MEDICAL INFO

Physician Name _____ Phone No. _____
Special Medical Needs _____
Allergies _____
Medicines Regularly Taken _____

EMERGENCY CONTACTS

Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____

AUTHORIZED PICK-UP

Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____

OTHER INFORMATION

Sibling _____ Gender _____ Age _____ Grade _____
Sibling _____ Gender _____ Age _____ Grade _____
Sibling _____ Gender _____ Age _____ Grade _____

I certify that the abovementioned information is accurate to the best of my knowledge.

Signature _____ Date _____