B Royal Academy Exploratory Arts School for Girls
Perfecting Education and Adoration Through Artistry

11046 Harts Rd.
Jacksonville, Florida 32218
Phone: (904)352-0534
Email: info@broyalacademy.com

B ROYAL ACADEMY ADMISSIONS PACKET

STUDENT CHECKLIST

STUDENT NAME:

____ Student IEP (ESE Students Only)
____ Withdrawal Form from previous school
____ Last Report Card
____ Immunization Records (Yellow)
____ Health Exam (Blue)
____ Student Birth Certificate
____ Social Security Card
____ One head shot photo
____ Parents Social Security Card
____ School Appointment (Date:_____)
____ Student Data Collection Form (FLDOE)
____ Parent Affidavit (FLDOE)
____ Proof of Income
____ Food Stamps Info (SNAP)

Train up a child the way he should go and when he is old he will not depart from it
Proverbs 22:6

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REGISTRATION

PERSONAL INFORMATION (please print clearly)

Students Last Name: _____ First Name:_____

Grade:_____ Age:_____ Gender:_____ Ethnicity:_____

Date of Birth:_____ City :_____ Country:_____

Address:_____ Apt #: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____

Mother's Name:_____
Phone:_____

Place of Employment:_____ Phone:_____

Email (print clearly):_____

Father's Name:_____
Phone:_____

Place of Employment:_____ Phone:_____

Email (print clearly): _____

EMERGENCY CONTACTS In case child listed above becomes ill or injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name: Relationship: Phone:

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_____ _____ _____\

_____ _____ _____

_____ _____ _____

In the event I cannot be contacted, I authorize the appropriate school official to take steps necessary to seek emergency medical attention for my child:

Conditions/Allergies: _____

Family Physician: _____ Phone:_____

Dentist: _____ Phone:_____

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EMERGENCY CONTACTS

Student Name: _____

Street Address: _____

City:_____ State:_____ Zip Code:_____

Name of Parent/Legal Guardian, if under 18:_____

Home Phone: _____ Cell Phone: _____

Work Phone:_____ Other:_____

In case of emergency: _____

Relationship:_____ Phone: _____

In case of emergency: _____

Relationship:_____ Phone:_____

In case of emergency:_____

Relationship:_____ Phone:_____

AUTHORIZED PICK-UP

Name: _____ Name_____

Phone:_____ Phone:_____

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Name: _____ Name:_____

Phone:_____ Phone:_____

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B ROYAL ACADEMY TRANSPORTATION SIGN UP FORM

Complete this form to request bus service. We will be providing limited transportation services this year for students and it will be on a first come first serve basis. Please Allow 5-7 business days for a request to be initiated and approved.

Full Payment of $420 will be due with monthly or weekly. If you need other payment options, arrangements must be determined directly from our director.

Registration Date: _____ **School Year:**_____

Students First and Last Name:

_____

Date of birth:

_____

Address:

_____

Phone:

_____

Parent/Guardian Name:

_____

Email Address:

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Grade:

Alternate Address: If the pick-up and/or drop-off location is different than the home address, indicate below. Alternate addresses must be consistent. **Alternate Pick-Up Address:**

Alternate Drop-off Address:

Signature of Guardian/Parent: **Date:**

_____ _____

_____ My child does not need school transportation.
Please be sure to complete this portion just in case your request in denied,

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After School Arrangements

When School is over my child will:

_____ Walk _____ Metro Bus _____ Will be picked up at 2:30 pm

_____ Private Bus Service _____ Other: _____

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Authorization to Dispense Medication

Per Chapter 464, Florida Statutes governing the practice of nursing and HRS Manual 150-25a regarding the dispensing of medication in Florida schools, no medication may be dispensed by the medical assistant from the school clinic without permission granted by a licensed physician. Furthermore, such dispensing of medication may not be by general permission only, but the specific medication must also be authorized.

In order for Royal Prep Academy to dispense any medication, including over-the-counter medication, both you and your child's physician must sign this form.

Name of Student: _____ Date of Birth: _____

Teacher and Grade: _____ Date:_____

Over-the-Counter Medication and Prescription Medication

Over-the-counter medication: Doctor, please check which medication(s) may be administered to your patient during school hours

☐ Tylenol _____

☐ Ibuprofen _____

☐ Benadryl _____

☐ Antacid _____

☐ Cough Drops/Throat Lozenges_____

☐ Other_____

Please give dosage times, and directions for each medication marked. Please List any possible side effects and/or special instructions.

Prescription medication that is to be administered daily or for an extended period of time:

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Diagnosis:_____

Medications(s): _____

Please give dosage, times, and directions on the reverse side for each medication.
Please list any possible side effects/and or special instructions on the reverse side.

NOTE: Medication must be supplied in the original prescription container. Ask pharmacists to divide the medication into two completely labeled containers, providing one for home and one for school.

_____ _____

Print Name or Stamp Physician | Physician Signature

_____ _____

Physician's Phone Number | Physicians Fax

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Emergency Health Care Information (2nd-8th)

Student's Name_____ SS#:_____ Sex:_____ Age:____

Date of Birth:___/___/___ Grade in School:_____

Address:_____

Phone: (___)_____ Cell: (___)_____

Mother/Guardian:_____ Home#:_____
Work#:_____

Email:_____

Father/Guardian:_____ Home#:_____
Work#:_____

Email:_____

Person to Contact in Emergency :

Relationship to student:_____ Name:_____
Phone:_____

Relationship to student:_____ Name:_____
Phone:_____

Relationship to student:_____ Name:_____
Phone:_____

Personal Family Physician_____ Office#:_____

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Dentist Name:_____ Office #:_____

Health Insurance Co. & Policy Number:_____

Part 2: Medical History (to be completed by parent/guardian). Explain "yes" answers below. Circle questions you don't know the answer to.

1. Have you had a medical illness or injury since your last checkup?
2. Do you have an ongoing chronic illness?
3. Have you ever been hospitalized overnight?
4. Have you had surgery?
5. Are you currently taking any prescriptions or non prescriptions (over-the-counter)?
6. Are you currently taking any supplement or vitamins to help you gain or lose weight or improve your performance?
7. Do you have any allergies(for example, to pollen, medicine, food, or stinging insects)?
8. Have you ever had a rash or hives develop after exercise?
9. Have you ever passed out during or after exercise?
10. Have you ever been dizzy during or after exercise?
11. Have you ever had chest pain during or after exercise?
12. Do you get tired more quickly than your friends during exercise?
13. Have you ever had racing heart or skipped heartbeats?
14. Have you had high blood pressure or high cholesterol?
15. Have you ever been told you have a heart murmur?
16. Do you have any current skin problems?
17. Have you ever had a head injury or concussion?
18. Have you ever had a seizure?
19. Do you have frequent or severe headaches?
20. Have you ever become ill from exercising in the heat?
21. Do you cough, sneeze, wheeze or have trouble breathing during or after activity?
22. Do you have asthma?
23. Have you had any problems with your eyes or vision?
24. Do you wear glasses, contact or protective eyewear?

***MAY TYLENOL/ADVIL/BENADRYL BE GIVEN? YES___ NO___

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_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Students_____ Date:_____

Signature of Parent Guardian_____ Date:_____

PERMISSION TO ADMINISTER EMERGENCY MEDICAL CARE/WAIVER OF RESPONSIBILITY AND PERMISSION:

I/We, _____, hereby give permission for the above name student to receive emergency medical treatment, including surgery, by a physician, hospital, or other provider of healthcare, in the event that the parent(s) legal guardian(s)cannot be contacted. It is also understood that financial responsibility for medical treatment or services is that of the parent(s) legal guardian(s) individually or through their family medical coverage. In consideration of the benefits to be derived, and in view of the fact B Royal Academy is an education institution, in which enrollment is voluntary, and having full confidence that every precaution will be taken.

Signature of Parent/Guardian:_____ Date:_____

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PHOTO / VIDEO RELEASE AUTHORIZATION

B Royal Academy periodically makes snapshots of students while engaged in school activities such as academics, exploratory arts, school spirit and extended day programs. It is our desire that you will grant permission for the photographing or videographing of your child. Please sign and date and return this form.

Parents / Legal guardian please fill out this form to allow your child to participate in B.R.A photographing and video taping of events at the school. Please fill out all information below:

Student Name _____
Student's Grade (circle) K 1 2 3 4 5 6 7 8 9
Parents/ Legal Guardian _____
Address _____
City, State Zip Code_____
Phone _____
School Name: B Royal Academy Exploratory Arts School for Girls

In consideration of the opportunity to help my child's school B.R.A develop a photo history, yearbook, video and other community media activities (television, extracurricular activities) presentations that will display the awesome atmosphere of building families and community growth. In connection with the appearance and performance of (name of child) _____ In an audiovisual work in which He/ She participates in, I hereby consent and agree to the reproduction and use of such footage (including audio track) containing my child's performance, name, voice and likeness as the same maybe edited, modified and revised by B.R.A and its designed agencies, without restrictions as to territory, frequency, duration and manner of media usage. I further understand that B.R.A will be the sole owner of the work, the re-recorded work, and any and all broadcast and any other advertising material produced utilizing the foregoing works and all rights therein, including but not limited to the world copyrights. I, the undersigned, represent that I am the Parent/

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Legal guardian of the minor named above and as such I am fully authorized and entitled to enter into this agreement on his / her behalf and do hereby agree to the above terms and conditions.

_____ _____

Signature of minors Parent or Legal Guardian Date

FIELD TRIP PERMISSION FORM

Dear Parent(s) or Guardian(s): As a part of your child's educational experience at B Royal Academy, your child's teachers and administration have planned extended experiences and or field trips for your child's enrichment. Students will be transported by bus or van, whatever best accommodates the class size. Trips are subject to change due to academic scheduling, weather, testing, etc.

I / We consent to _____, accompanying his / her class / group on the planned and supervised field trip and I agree to release and discharge B.R.A its offices, agents, and employees exercising reasonable care within their scope of employment from liability (all claims and demands / rights and cause of action) growing out of personal injuries and property damage resulting or occurring during the aforementioned activity, or in transit to and from said activity.

_____ _____

Parent or Guardian Date

(Chaperones are always needed and welcomed)

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B ROYAL ACADEMY EXPLORATORY ARTS SCHOOL FOR GIRLS

For office uses Only: McKay Scholarship Program Student accepted for Grade_____ HEROES Scholarship Program Student accepted for Grade_____ Private Pay Student accepted for Grade_____ Step up for Students Scholarship Program Student accepted for Grade_____ Registration amount paid $_____Date Paid_____ Receipt # _____ Books Paid $_____ Date Paid_____ Receipt#_____ Planner Paid _____Receipt#_____ Satchel Paid $_____ Date Paid_____ Receipt #_____ Uniforms Paid _____Receipt#_____ Transportation Paid $_____Date Paid_____ Receipt#_____ Start Date ____/_____/_____ Extended Day Paid $_____ Date Paid _____ Receipt# _____
