Student Form
2019 / 2020 Academic Year

Divine Mercy Catholic Academy
1940 N Courtenay Parkway
Merritt Island, FL 32953
321-452-0263 FAX 321-453-7573

Student Name: _____
Date of Birth: _____
Student's Gender: Male _____ Female _____
Grade in 19/20 School Year: _____
This student requires special services: Yes _____ No _____ Type of services _____
This student qualifies for a McKay Scholarship: Yes _____ No _____
This students qualifies for a Step Up For Student Scholarship: Yes _____ No _____

Primary Contact Information:

In case of emergency, who should be contacted first? Mother _____, Father _____, or Other_____

Parent / Guardian
Name: _____
Relationship: _____
Home Phone: _____
Work No.: _____
Cell No.: _____

Parent / Guardian
Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell No.: _____

Is there someone to whom your child may not be released? _____

Contacts (other than parents) to whom your children may be released:

1) Name:_____ Relationship: _____ Daytime #: _____

2) Name:_____ Relationship: _____ Daytime #: _____

3) Name:_____ Relationship: _____ Daytime #: _____

4) Name:_____ Relationship: _____ Daytime #: _____

5) Name:_____ Relationship: _____ Daytime #: _____

In the event your child has an accident or serious illness at Divine Mercy Academy, we will make every attempt to contact you first and foremost, or the contacts noted. However, if the school fails to reach you or a designated contact, the physician indicated on this form will be called for instruction. **Therefore, it is very important that the information which the school has on your child is always current and accurate.** If your child needs emergency care, and/or transport by ambulance, this "Release" authorizes Divine Mercy to arrange for such care or transport.

Student's Ethnicity:

Hispanic/Latino ____ Non Hispanic/Latino _____

Student's Race:

Asian _____ Native American / Other Pacific Islander _____
American Indian/Native Alaskan _____ White _____
Black / African American _____ Two or more Races _____

Primary Language Spoken at Home

English _____ Spanish _____ Other _____

Medical Conditions:

__ Asthma __ Hypoglycemia __ Hyperactive
__ Diabetic __ Visual __ Epileptic
Other:_____

Known Allergies:

Bee/Wasp/Red Ant Bite _____ Medicines: _____
Food/Types: _____ Other: _____

Medical:

Physician's Name: _____ Insurance Co Name: _____
Daytime Phone #: _____ Group #: _____

Sacraments Received: (Y/N)

Baptism: _____ Eucharist: _____
Penance: _____ Confirmation: _____

Permission is granted for the school to conduct the following screenings:

Vision: _____ Hearing: _____ Scoliosis (applicable to 6th grade): ____

NEW STUDENTS:

- Did this student attend VPK? If so, where? _____
- All students entering Divine Mercy Catholic Academy for the first time will be accepted on a **probationary basis** for a nine week period, to ascertain their ability to adjust to the school's philosophy and program.
- All students entering Divine Mercy Catholic Academy for the first time must submit current and/or previous IEP (Individual Education Plan) / Service Plan prior to acceptance.

State of Florida, County of Brevard ***In cases of JOINT CUSTODY, both parent's signatures are required***

_____, parent / guardian of the child named above, who is personally known to me or who has shown the following identification _____ has been duly sworn and subscribed before me this _____ day of _____ (month), _____ (year) and agrees to the above "Release Form" and will abide by its contents.

Signature of Parent / Guardian: _____

Signature of Notary Public: _____

NOTARY STAMP: