958 N Valley Forge Rd, Devon, PA 19333 Ph.: 610-207-8973 Email: admin@suffah.academy

Registration Requirements

Suffah Academy is accepting registration for the current academic year. To register your child or children please visit our website, (https://suffah.academy/), to complete the registration form and make a deposit to hold a spot for your child. Upon completion and submission of the form, you will receive this document by email to complete the registration process.

We also have created a handbook for parents which has very important information about school policies and requirements. Please visit https://suffah.academy/ and choose "for Parents" to see the handbook and other important information.

We will need the following to complete the registration of your child:

- Copy of Child's Birth Certificate *
- Physical/health history form- must be signed and stamped by your child's physician and dated within 1 year *
- Permission to administer medication *
- Emergency Contact Form *
- Photo/Video release *
- Technology agreement *
- ESL Waiver *
- Copy of updated immunization record *

***THESE REQUIREMENTS CAN NOT BE WAIVED EXCEPT WITH THE EXPRESSED PERMISSION OF THE CHIEF SCHOOL ADMINISTRATOR.**

Suffah Academy Registration Application Form

STUDENT'S NAME:

(Last) _____ **(MI)**_____ **(First)**_____

CLASS / GRADE: _____

Date of Birth (M/D/Y): _____ **Place of Birth:** _____

Parent (Guardian) Name: _____

Address: _____

Telephone Number: Home_____ **Work** _____ **Mobile:**_____

Email: _____

Health History

Disease History	If yes, please note the type and year, If no, please note "None"	Disease History	If yes, please note the type and year, If no, please note "None"
Allergies		Convulsive d\Disorder	
Drug sensitivities		ADHD	
Lyme Disease		Diabetes	
Hepatitis		Heart Disease	
Neuromuscular Disease		Hearing Disorder	
Asthma		Vision Disorder	
Chicken Pox		Congenital Disease	

Operations/Injuries (please specify). If none please note "none"

1:_____ **2:**_____ **3:**_____

For Office Use:

Date Application Received:_____ **Deposit Received:** _____

Registrar Signature: _____

EMERGENCY CONTACT FORM

STUDENT'S NAME: _____
(Last) (MI) (First)

Student date of birth:_____Gender: M___F____

Mailing Address:_____

Name of Mother/Step-Mother/Guardian (circle one) _____

Home Phone #_____Cell Phone #_____Work Number_____

Occupation_____

Name of father/Step-father/Guardian (circle one) _____

Home Phone #_____Cell Phone #_____Work Number_____

Occupation_____

Student primarily lives with:_____Both Parents ____Mother ____Father ____Parent/Step-Parent ____Guardian(s)

If the student's biological parents reside together, they are: _Married ____Single/Living Together

If the student's biological parents do not reside together, they are: _Separated ____Divorced __Single ____Widowed

If you are this student's guardian, indicate your relationship to student_____

Are there custody or guardianship documents for this student? ____Yes ____No

Please Note: If there are court documents regarding parental custody or guardianship, a copy must be on file with Suffah Academy. Please call 610-207-8973 for more information

EMERGENCY CONTACTS: PLEASE LIST PERSONS OTHER THAN YOURSELF WHO YOU AUTHORIZE TO RECEIVE PHONE CALLS OR PICK UP THIS STUDENT IN THE EVENT THAT YOU CANNOT BE REACHED. WE **WILL NOT** ALLOW PERSONS OTHER THAN THOSE ON THIS LIST FOR PICK UP FROM SUFFAH ACADEMY. PLEASE MAKE SURE TO CALL THE SCHOOL AHEAD OF TIME IF THERE ARE ANY CHANGES TO THE REGULAR SCHEDULED PICKUP PERSONS. ALL NAMES AND IDS MUST MATCH.

Name	Phone #	Relationship to Student
Name	Phone #	Relationship to Student
Name	Phone #	Relationship to Student

Parent/Guardian Email Address_____

Family Physician_____

Phone #_____

In case of emergency, I hereby give permission for this student to be taken to the hospital for treatment, if necessary. Please provide a preferred hospital name and address, if desired.

_____

Signature of Parent/Guardian Date

Is this student covered by health insurance: Yes___No_____

Name of the insurance company: _____Number:_____

ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF MEDICAL EQUIPMENT IN SCHOOL

If your child requires medication at school, please request for administration of medication, treatments, or use of equipment in school. Please remember school personnel will not administer any medication without a signed document by the child's Physician **AND** parent/guardian's written approval. All medication administered at school must be kept in the original container. Medications will be administered by principal, or principal's designee. Non-prescription medicine will not be administered.

For Physician

The below named student must take prescribed medication during school hours as it is required to be administered more than three times a day and cannot be given at home only.

Name of Student:
(LAST) (FIRST) (MI)

Diagnosis: _____

Medication prescribed: _____

Dosage required: _____

Time during school day to be given: _____

Duration of medication: _____

Possible side effects/adverse reaction: _____

Child is able to self-administer inhaler/EpiPen: _____

Physician's Name and Signature _____

Date: _____ Contact number: _____

Parent (guardian) name and signature: _____

TECHNOLOGY/TABLETS/CELL PHONES FORM

Suffah Academy does not allow the use of personal tablets by students at any time during school hours. Please do not bring such items to school. Teachers may confiscate such items which will require parents to come to school to have items returned.

Cell phone use during school hours is prohibited unless an emergency situation should arise or under special circumstances. Special permission must be obtained beforehand to avoid disciplinary action. All cell phones must be turned off during school hours.

Suffah Academy is not responsible for, nor can be held liable for any activity on such devices before, during, or after school hours.

I have read & understood the above.

_____

Parent/Guardian Signature Date

HOME LANGUAGE/ESL & SPECIAL EDUCATION

I have discussed and acknowledged Suffah Academy's policy regarding ESL & Special Ed. I do not hold Suffah Academy liable for classes or support related to these services.

Parent/Guardian Signature Date

_____

PHOTOGRAPH/VIDEOTAPERELEASE Form

Suffah Academy may occasionally take pictures and videos of children enrolled. Such material may appear in the school's printed materials such as brochures, teacher training videos, and/or social media or Web site.

Please check one of the following:

- o I authorize the reproduction of any photographs, videos, or slides of my child or their work for use by Suffah Academy and/or NJDOE.

- o I do not authorize the reproduction of any photographs, videos, or slides of my child or their work for use by Suffah Academy and / or NJDOE.

Parent/Guardian Signature: Date:

_____

Please add any other comments you may have that school should know about your child.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

⓺ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
⓺ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
⓺ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
⓺ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
⓺ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
⓺ YES ⓺ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ⓺ YES ⓺ NO	**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.