Tranquility Adventist School

"Educating for Eternity"

3 Academy Lane, Andover, NJ 07821
(908) 852-1391
www.tranquilityschool.com
principal@tranquilityschool.com

STUDENT ID # _____ (OFFICE USE ONLY)

STUDENT ADMISSION APPLICATION

Student's First Name:	Middle Name:	Last Name:
Address:	City/State/Zip:	Home Phone:
Date of Birth:	Gender: ( )Female ( ) Male	Grade Entering:
Place of Birth (City/State/Country)	Is Student a Baptized Member of the SDA church? ( )Yes ( ) No Date: _____ Church: _____	
Ethnicity: Hispanic/non-Hispanic	Country of Citizenship:	Enrollment Date:
Race: __White __Black __American Indian __Asian __ Pacific Islander __Multiracial	Language spoken at home:	

Siblings/Name/Age: _____ _____

_____ _____

_____ _____

FAMILY INFORMATION

Marital Status of Parents: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MOTHER/GUARDIAN	FATHER/GUARDIAN
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Alternative Phone# (if any):	Alternative Phone # (if any):
E-mail:	E-mail:
Occupation:	Occupation:
Baptized SDA? Yes No (if yes) Church Membership: _____ (if no) Which denomination: _____ ___Non-Denominational ____Prefer not to answer.	Baptized SDA? Yes No (if yes) Church Membership: (if no) Which denomination: _____ ___Non-Denominational ____Prefer not to answer.

EMERGENCY/AUTHORIZED PICK UP CONTACT INFORMATION

The individuals listed below have permission to pick up my child/children after school. In the event of an emergency or late pick-up, parents will always be contacted first.
**Unknown adults by staff will be asked for identification the first time they pick up and/or if there is a staff member who does not recognize individual for the safety of students.

A message should be sent via Remind (our communication app) to inform of pick-up by someone other than parent/guardian and they must be on this list.

Student Name(s)

Only 2 emergency contacts are required, but you may list as many as you need other than parent/guardian. In case a parent/guardian can't be reached, please specify the next (one form per family)

Name	Relationship	Cell Phone #	Check if also authorized to pick up

Consent to Treatment Form

We, the undersigned parents or guardian of _____

Name of Student

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 said physician listed below or any physician the school or 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 below 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 ***Tranquility 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 below or to the school or organization entrusted with the custody of said minor.

The above named Student ☐ is ☐ is not covered by Health Insurance

Health Insurance Name	
Group #	
Member #	
Primary Doctor Name & Phone #	
Preferred Hospital in case of emergency	
Allergies	
Medication	

***Please include a copy of insurance card – front and back**

Parent's Signature _____ Date _____