

School Year _____

Cornerstone Academy of Eastside Praise **Returning Student Application**

Student's Full Name: _____

Grade Entering Fall: _____ Date of Birth: _____

Registering for the Following Program: (Please circle)

Part-Time Pre-Kindergarten (K4) Full Day Kindergarten (K5) Elementary (Grades 1st-5th)
Middle School (Grades 6th-8th) High School

Student lives with: _____

If the student is not living with both parents, please check the applicable reason:

____ Father Deceased ____ Mother Deceased ____ Parents Divorced
____ Parents Separated ____ Other (explain) _____

Parent(s)/Primary Legal Guardian(s): _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Primary E-Mail: _____

Father's Occupation & Place of Work: _____

Father's Cell Phone: _____ Father's Work Phone: _____

Mother's Occupation & Place of Work: _____

Mother's Cell Phone: _____ Mother's Work Phone: _____

Other Non-Primary Parent/Guardian Information for Record (If applicable):

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

Student Information

Does this child have any food allergies, allergies to medication, or any medical conditions which we should be aware of?

If yes, please describe: _____

Does the school have permission to give this child Tylenol for a headache?: _____

Please list any medications that the student takes regularly: _____

List any medication which will be left in the school office: _____

Emergency Information

Cornerstone Academy will always attempt to contact a parent first in the case of emergency or illness. Please list, in order, the names of additional contacts you would like us to call in the event a parent cannot be reached.

1. Name: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____
2. Name: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____
3. Name: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____

Name of Child's Physician: _____ Phone: _____

Name of Dentist: _____ Phone: _____

Health Insurance: _____ Policy Number: _____

Financial Information

Please check your choice of payment:

_____ 10 Month Payment Plan _____ Payment in Full Before June 1 (3% discount)

*No discount is given after June 1st

Name of the Financially Responsible Person: _____ Phone: _____

Statement of Fact

I certify that all the information on this application is true to the best of my knowledge. I have read all the informational materials and I agree to abide by the school's policies and procedures.

Signature of Parent or Legal Guardian

Date

Please return this form, along with the non-refundable Application Fee to:

***Cornerstone Academy of Eastside Praise
Attn: Admissions
6300 Billtown Road
Louisville, KY 40299***