



"The purpose and vision of VFCA is to provide Christian leaders, Godly men and women, to take places of authority in the world and in Christ's body of believers."

OFFICE USE ONLY

1. Date Received _____ Grade: _____
2. Medical Release _____
3. Birth Certificate _____
4. Immunization Record _____
5. Student Health Record _____
6. Transcripts Received _____
7. Interview _____
8. Excepted for Enrollment _____

ADMISSIONS APPLICATION

A. NONDISCRIMINATION POLICY: Valley Fellowship Christian Academy admits students of any race, color, nation, and ethnic origin to all rights, privileges, programs, and activities made available to students at the school. It does not discriminate on the basis of race, color, national, and ethnic origin in administration of its education policies, admissions policies, athletic, and other school administered programs.

B. GENERAL RECORD:

Student Information

First Name _____ Middle Initial _____ Last Name _____

Name the student prefers to be called _____

Gender _____ Date of Birth _____

Student lives with: (circle one) father, mother, both, or other _____

Application for grade _____ Previous grade completed _____

Student's Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Parent Information

Father Mother Guardian (Please circle one)

First Name _____ Middle Initial _____ Last Name _____

Work Phone _____ Ext. _____ Cell Phone _____

Occupation _____ Employer _____

Email: _____

Father Mother Guardian (Please circle one)

First Name _____ Middle Initial _____ Last Name _____

Work Phone _____ Ext. _____ Cell Phone _____

Occupation _____ Employer _____

Email: _____

Student's Educational History:

Previous school attended: _____

How long in attendance? _____

If less than 2 years, last prior school: _____

Were you ever denied admission to a school? ____ Why? _____

Were you ever suspended or expelled from school:

When? _____ Why? _____

C. FINANCIAL RECORD

COMBINED INCOME RANGE: (Please check one)

less than 20,000 30,000 to 39,999

20,000 to 24,999 40,000 to 59,999

25,000 to 29,999 60,000+

Have you reviewed a price sheet and considered the total cost of attendance? _____

Is there any reason why you would not be able to make the financial obligations of enrollment? _____

D. FAMILY'S SPIRITUAL RECORD

Home Church (Name) _____

Address _____ Phone: _____

Denomination _____

Senior Pastor _____ Youth Pastor _____

Do you attend one service per week for three (3) out of four (4) weeks in a month? Yes ____ No ____

Has the student accepted Jesus Christ as your personal Lord and Savior? Yes ____ No ____ Year _____

Have the parents/guardians accepted Jesus Christ as their personal Lord and Savior? Yes ____ No ____

Has the student been water baptized? Yes ____ No ____ Year _____ The parents? _____

Has the student received the baptism of the Holy Spirit with the evidence of speaking in other tongues?

Yes ____ No ____ Year _____ If no, are you open to this experience? Yes ____ No ____

Have the parents received the baptism of the Holy Spirit with the evidence of speaking in other tongues?

Yes ____ No ____

E. STUDENT'S MEDICAL HISTORY

Have you ever had any of the following?
Please check each item yes or no:

	YES	NO		YES	NO		YES	NO
Allergies			Ear Disease, mastoid			Pneumonia		
Anemia or other blood disease			Eczema			Rheumatic fever		
Anxiety			Encephalitis			Rubella		
Appendicitis			Epilepsy			Rupture or hernia		
Arthritis			Glandular disease			Scarlet fever		
Asthma			Hay Fever			Sinus trouble		
Bronchitis			Heart Disease			Thyroid trouble		
Cerebral Palsy			Hepatitis			Tonsillitis		
Chicken Pox			Kidney stone or disease			Tuberculosis		
Chorea			Malaria			Typhoid fever		
Colitis			Measles			Scarlet fever		
Convulsions			Meningitis			Ulcer, duodenal or stomach		
Deafness			Mononucleosis			Venereal Disease		
Depression			Nervous or mental disease			Whooping Cough		
Diabetes								
Diphtheria			Pilonidal cyst			Other		

Check the following symptoms that have been serious. Underline those that are frequent:

Sore throat _____, Colds _____, Earache _____, Boils _____, Chronic cough _____, Bloody sputum _____,

Hoarseness _____, Nausea _____, Night Sweats _____, Vomiting _____, Colic _____, Sore mouth _____,

Jaundice _____, Indigestion _____, Constipation _____, Pain in chest _____, Rapid heart _____,

Headache _____, Nervousness _____, Migraine headache _____, Sweating of hands and feet _____,

Skin trouble _____, Shortness of breath _____, Urinary symptoms _____, Swelling of hands & feet _____,

Others (list): _____

Please check each item yes or no:	Yes	No	If yes, explain below
1. Have you ever been unable to attend school because of your health?			
2. Have you ever been unable to take physical education or participate in sports because of your health?			
3. Have you consulted or been treated by a clinic or physician in the past 5 years?			
4. Have you ever been hospitalized for a mental or nervous disorder?			
5. Have you ever had any serious illness, injuries, or operations not listed above?			
6. Do you take any daily medications? If so, please explain what specific medication you use and why.			

The State Health Department requires a verified copy of student's immunization record from a physician or from the Health Department.

Has your child ever had a professional:

	YES	NO	BY	DATE
VISION examination				
HEARING examination				
PHYSICAL examination				
DENTAL examination				

Does your child wear glasses? Yes ____ No ____ Contacts? Yes ____ No ____

Does your child wear a hearing aid? Yes ____ No ____

List two neighbors or relatives who will assume responsibility of your child if the school is unable to contact you.

Name: _____ Name: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Other Information _____

Family Doctor: _____ Phone: _____

Hospital Preference: _____

Insurance Company: _____

Insurance Policy number: _____

If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his instructions. If it is impossible to contact this physician, the school may make necessary arrangements.

Parent's or Guardian's Signature: _____

PLEASE LIST ANY ALLERGIES OR HEALTH PROBLEMS THAT YOU WOULD LIKE FOR YOUR CHILD'S TEACHER TO BE AWARE OF:

G. STUDENT QUESTIONNAIRE: (GRADES 4-12)

After reading and understanding the student handbook, are you willing to submit yourself to the leadership of Valley Fellowship Christian Academy and its rules and regulations? ____ Yes ____ No

Have you used drugs, alcoholic beverages, or used tobacco within the last 6 months? ____ Yes ____ No

If yes, please explain: _____

What are your favorite subjects? _____

What subjects are the most difficult for you? _____

Why do you feel that you should be accepted as a student at Valley Fellowship Christian Academy?

If you are accepted as a student at Valley Fellowship Christian Academy, what type of student would you be?

What are some goals that you have for your life?

Student Signature _____

AFFIRMATION:

I hereby affirm that all of the information contained in this application is true and accurate to the best of my knowledge. I understand that providing any false information would be sufficient reason for the rejection of this application. I further understand that I may be asked for additional written affirmation concerning such items as academic record and financial income.

NOTE: *This application does not assure final enrollment, but provides information upon which a decision will be based. After acceptance, the registration fee is non-refundable. Before the application is final, a copy of the birth certificate and immunization record must be received.*

_____/_____
(Parent/Guardian) (Date)

_____/_____
(Parent/Guardian) (Date)

Mail application to:



**3616 Holmes Avenue
Huntsville, Alabama 35816**

or Fax application to:

(256) 533-5253

Contact Information:

Website: valleyfellowship.com

Phone: (256) 533-5248