NEW STUDENT ENROLLMENT PROCEDURE

Student Name: _____ Grade:_____

Address: _____

_____ Phone: _____

THANK YOU FOR YOUR INTEREST IN LA SIERRA ACADEMY!

1. **Please find below the documents and steps necessary to complete the application process.**

   _____ A completed application form

   _____Transcript and final grades (if available) from your previous school.

   _____ Two student recommendation forms filled out by a teacher and a principal or pastor.

   _____ Scores from Iowa Assessment test or other standardized test.

   _____ A copy of the student's immunization records

   _____ Please pay the $125 non-refundable application fee at the business office.

2. _____ Please call (951) 351-1445, ext. 210 to schedule an interview with the Principal, Iveth Valenzuela.

4. _____ **Health office requirements –** we can accept your student without all health requirements completed, however please keep in mind that all Health Office requirements must be completed before a student can start attending classes.

5. _____ Upon receiving notice of acceptance, please make financial arrangements with the business office for tuition and comprehensive fees.

4900 GOLDEN AVE, RIVERSIDE, CA 92505
OFFICE: 951-351-1445 • WEB: LSAK12.COM • FAX: 951-689-3708
Learning, Serving & Achieving through Christ

7-12 Grade Student Application

OFFICE USE ONLY	DATE	INITIAL
Application Received		
References Received		
Physical Received		
Immunizations Received		
New Student Interview		
Entrance Test		

FINANCIAL CLEARANCE

☐ $125 Application Fee ($100 if before March 7, 2014)
Cash_____ Check # _____ Credit Card _____
Received by _____
Financially cleared on _____
by_____

New _____ Return _____

Accept_____ Deny _____

Date Started_____
☐ Birth Certificate
☐ Cum File Requested
Date: _____

ROUTED TO:
☐ Business Office
☐ Registrar/JH Sec.
☐ Principal

Student Information

Last Name	First Name	Middle Initial	Gender	School Year	Grade Entering

Student Cell Phone	Student E-mail address	Birthdate/Age	Ethnicity(statistical purposes)	Baptized SDA? (mo/day/year)	Church of Membership

Family/Parent/Guardian Information

Parent Name (Last, First)	Parent Name (Last, First)
Relationship	Relationship
E-mail Address	E-mail Address
Mailing Address	City, State ,Zip

Home Phone	Cell Phone	Work Phone	Cell Phone	Work Phone

Occupation/ Employer	SDA Member ☐ Yes ☐No	Church Where Membership is held: (SDA or Other)	Occupation/ Employer	SDA Member ☐ Yes ☐No	Church Where Membership is held: (SDA or Other)

Secondary Residence

Send correspondence to this address also ☐ Yes ☐No

Parent Name (Last, First) Does parent have joint custody ☐ Yes ☐No	Address

Email Address	Cell Phone	Work Phone	Occupation/ Employer	SDA Member (please check) ☐ Yes ☐No	Church Where Membership is held: (SDA or Other)

Siblings Attending La Sierra Academy

Name/Grade	Name/Grade

Authorized Release / Emergency Contact Information

Please list adults other than parent or guardian over 18 with whom your child may leave campus. ID may be required.

Name/Phone	Relationship
Name/Phone	Relationship
Name/Phone	Relationship

New Students

Name of Last School Attended	Phone Number

Accommodations/Court Orders

Has this student had any accommodations/learning problems/IEP in the previous school? Is there a court order we should be privy to? Please explain

How did you hear about us (check all that apply)? ☐ School website ☐ Friend ☐ Church ☐ Word of Mouth ☐ Internet ☐ Other (please specify source):

Junior High Students

Music class preference (choose one)
☐ Band (must have some knowledge of a band instrument)
☐ Choir

T-Shirt size (adult sizes only)

☐ Small ☐ Medium ☐ Large ☐ X-Large

11th and 12th Grade Students

La Sierra Academy extends Lunch off-campus privileges to 11th and 12th grade students who have signed parent permission to leave campus. This privilege is contingent upon acceptable behavior and grades, and can be revoked at any time by School Administration. This permission to leave campus is only for lunch hours, and does not extend to times when students are working on campus or have a Study Hall. Please indicate if your student has permission to leave campus at lunch.

☐ I grant permission for my son/daughter to leave campus at lunch.
☐ I **do not** grant permission for my son/daughter to leave campus at lunch. Parent Signature: _____

Permission to Post Photos/Videos/Work

La Sierra Academy advocates celebrating the accomplishments of our students and showcasing their achievement through different kinds of publications, as well as online. To protect our students, we require the parental or legal guardian written permission before placing student photos, images, videos, and works online or in school printed publications. Please indicate if we have your consent to publish photos, videos, and work of your student.

☐ I approve and grant permission for my student's photo/work/video to be posted and used online or in the La Sierra Academy publications. I acknowledge and affirm that I have the legal right to grant such consent.

☐ I **do not** approve or grant permission for La Sierra Academy to use my student's photographs, images, videos, or work online or in school publications.

Financial Information

Do you have an unpaid account at another SDA School? ☐ No ☐ Yes If yes, please give name and address of school

Who is financially responsible? ☐ Father ☐Mother ☐Other
Social Security # of financially responsible party:
_____

Split Bill: ☐ Yes ☐No If yes, please explain

Consent to treatment and Medical Information

Medical Conditions & Medications

Allergies

☐ Check box is allergy requires an Epi-pen.

First Aid: I do hereby consent to reasonable and prudent first aid to be administered by school personnel to the said minor as circumstances merit.
Medical: If emergency service involving medical attention or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student/ as shall be necessary in the medical opinion of the doctor rendering service. This authorization is given pursuant to the state Civil Code Sec. 25.8.

Parent/Guardian Signature: _____ Date: _____

We the undersigned, pledge to uphold the policies and principles as outlined in the current La Sierra Academy student handbook and to accept full financial responsibility according to the published financial policies and contract. To the best of our knowledge the questions on this application are answered completely and truthfully.

_____ _____ ____/_____/____
Signature of parent/guardian *Student signature* *Date*

Student Recommendation Form

_____ is applying for admission to La Sierra Academy (7-12). Please complete this recommendation form as all applications require a completed recommendation form from the previous school. The information you provide will be kept strictly confidential. Thank You.

In what capacity have you known this student? ____ Principal ____ Teacher ____ Pastor

How long have you known this student? ____ 1 - 2 years ____ 3 - 4 years ____ 5 or more

I am familiar with La Sierra Academy's Program: ____ Not at All ____ Somewhat ____ Fairly ____ Very Familiar

How would you rate this student in the following areas?

	EXCELLENT	AVERAGE	POOR	N/A
Academic Ability				
Study Habits				
Motivation				
Leadership Potential				
Effort & Perseverance				
Positive Influence				
Dependability				
Level of Maturity				
Personal Conduct				
Obedience to Regulations				

General Comments: (Consider maturity, integrity, behavior, relationship with peers, etc.)

_____

_____

_____

I recommend this student for admission to La Sierra Academy: ____ Yes ____ No ____Yes, with reservations

Your name: _____ Position: _____

Subject(s) you taught applicant: _____ Grade Received: _____

School: _____ School Phone:_____

School Address: _____

Signature:_____ Date:____/____/_____

4900 GOLDEN AVE, RIVERSIDE, CA 92505
Phone 951-351-1445 Fax 951-689-3708
www.lsak12.com

Health Office Requirements for Junior High

- **Physical:** All Students should have one physical examination fully completed for their health records.
  - **All 7th grade students** are required to submit a **new** Physician's examination with evidence of completed scoliosis screening dated within 1 year prior to school entry.
  - **New 8th grade students** transferring from another school must provide a copy of completed physical examination within 2 years prior to school entry.
  - **7th and 8th grade students** seeking to participate in a LSA athletic team must complete a Sports Physical examination prior to the first scheduled game.

- **Medications:** If your student will need medication(s) during school hours. List one medication per form that applies (Note: *Physician* and Guardian/Parent signatures are required for both forms):
  - Self-Medication Administration Consent Form
  - Administration of Medication by School Personnel Consent Form.

- **Immunizations:** A copy of your student's immunization record is needed for their health records. Allow physician to verify that current immunizations meet California's school immunization requirements
  - (Polio/Diphtheria, Tetanus, and Pertussis/Measles, Mumps, Rubella/Hepatitis B/Varicella/Tdap Booster).
  - **All students** entering, advancing or transferring into **7th grade** need proof of an adolescent whooping cough booster immunization (called "Tdap"). Record of receiving the **Tdap booster** on or after the student's 7th birthday is required prior to school entry.
  - Exemptions: The law allows parents/guardians to choose an exemption from immunization requirements based on their personal beliefs or medical conditions. A *Personal Belief Exemption to Required Immunization* form must be submitted to La Sierra Academy Health Office prior to entry, this form is provided by your physician.

- **TB Test:** Written evidence of a Mantoux or PPD skin test and results are required by La Sierra Academy under Southeastern California Conference policy. A chest x-ray in lieu of a Mantoux or PPD skin test will **not** be accepted.
  - **All 7th grade students** are required to submit evidence of a **new** Mantoux or PPD skin test and results within 1 year of school entry.
  - **New 8th grade students transferring from outside of California** are required to submit evidence of a Mantoux or PPD skin test and results within 1 year of school entry.
  - **New 8th grade students** transferring from within California must provide evidence of a Mantoux or PPD skin test and results within 2 years prior to school entry.

Thank you for your time and cooperation, please contact the La Sierra Academy Health Office with any questions regarding these requirements.

Sincerely,

Tiffany Ramos
Health Office, La Sierra Academy
(951) 351-1445 #212
tramos@lsak12.com

Revised: October 1, 2014

Revised 7/1/05
Mandatory

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex_____Age_____Date of birth_____

Grade_____School_____Sport(s)_____

Address_____Phone_____

Personal Physician _____

In case of emergency, contact:

Name _____Relationship_____Phone (H)_____Phone(W)_____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐

48. How old were you when you had your first menstrual period? _____
49. How many periods have you had in the last 12 months?_____

Explain "Yes" answers here:_____

_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete_____Signature of Parent/Guardian_____Date_____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____Date of Birth_____

Height_____Weight_____% Body Fat (optional)_____Pulse_____BP____ / ____ (____ / ____, ____/____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal_____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes: _____

_____

Name of physician (print/type)_____Date_____

Address_____Phone_____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____Sex_____Age_____Date of birth_____

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:_____
_____
_____
_____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason:_____

Recommendations:_____
_____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____Date _____

Address _____Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____Sex_____Age_____Date of birth_____

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:_____
_____
_____
_____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason:_____
Recommendations:_____
_____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____Date _____

Address _____Phone _____

Signature of physician _____, MD or DO

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STUDENT MEDICAL RECORD

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file.

Name_____ Birth Date _____

Address _____

_____ Social Security Number _____

Name of Father_____ Name of Mother_____

History (Past illnesses and allergies. Please check those he/she has had.)

- ❒ Cancer
- ❒ Chicken Pox
- ❒ Diabetes
- ❒ Diptheria
- ❒ Epilepsy
- ❒ Heart Disease
- ☐ Measles
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Tuberculosis
- ❒ Whooping Cough
- ❒ Ear Infections
- ❒ Other

Allergies:

- ❒ Asthma
- ❒ Hay Fever
- ❒ Insect Bites
- ❒ Penicillin
- ❒ Other Drugs

Explain briefly factors such as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience

_____

Indicate physical problem by check: Hearing ( ) Heart ( ) Sight ( ) Speech ( )

Other _____
SPECIFY

IMMUNIZATIONS - An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Records considered official are:

State Immunization Record
Health Provider Record - must have signature, stamp, or initials next to each date.
Physician's Record
County Health Department Record
Official Immunization Record from another state
School Immunization Record

LABORATORY RECORD

	Type*	Dates Given	Given by	Date Read	Read By		Impression
TB SKIN TESTS	❒ PPD Mantoux	/ /		/ /			❒ Pos
	❒ Other_____	/ /		/ /			❒ Neg
	❒ PPD Mantoux	/ /		/ /			❒ Pos
	❒ Other_____	/ /		/ /			❒ Neg
	❒ PPD Mantoux	/ /		/ /			❒ Pos
	❒ Other_____	/ /		/ /			❒ Neg

*If required by school entry, must be Mantoux unless exception granted by local health department

CHEST X-RAY Film date:_____/_____/_____ Impressing: ❒ normal ❒ abnormal

Person is free is communicable tuberculosis ❒ yes ❒ no

Signature/Agency _____

PHYSICIAN'S EXAMINATION*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	Explain Abnormalities
Skin				
Eyes, vision, glasses				
Ears, hearing				
Nose and throat				
Mouth, teeth, speech				
Glands				
Chest, lungs				
Cardiovascular, heart				
Abdomen, enlargement				
tenderness				
hernia				
Spine, back				
Scoliosis for Grade 7				
Posture				
Extremities				
Genitourinary				
Nervous System, reflexes				

Nutritional Status and general appearance of the child _____

_____

Recommendations for additional medical or dental care _____

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling.
❒ yes ❒ no

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted.

_____

Date _____ Physician's Signature _____

Address _____

* To be completed by the family physician and kept on file at the school for all children, a) entering school for the first time, b) at grade seven (this should include the scoliosis examination), c) at least once in grades nine through twelve, and d) at other grades, when required by the Conference Board of Education.

Last, First Name:_____ DOB:_____

School year: 2014-2015

Self-Medication Administration Consent Form

Name: _____

Date of Birth: _____ Grade: _____

Instructions: This form must be filled out and signed annually by the *student, parent/guardian* **and** *physician* before this medication can be administered during school hours. Please fill one form per medication.

Condition for which medication was prescribed: _____

_____

Medication: _____

Instructions for use: _____

Dosage: _____

Route: _____

Frequency: _____

Possible Side Effects: _____

This medication should be taken with the student on: (check all that apply)

□All Field Trips
□5th grade AstroCamp
□6th grade Out Door School
□7th grade Catalina Trip
□8th grade Washington DC Trip
□Jr. High & High School Sporting Activities
□High School Music Tour
□High School Mission Trip
□Other: _____

Student

I agree and feel competent to take my own medication as prescribed. I will not at any time share my medication with another student and I will keep medication secure from other students.

_____ _____

Signature of *Student* Date

Name of Parent/Guardian: _____

I understand and agree to the following:

1. I agree to assume responsibility for sending my child's medication in its original prescription container.
2. I agree to make certain that my child takes responsibility for taking the medication as prescribed.
3. I also agree that the Southeastern California Conference, La Sierra Academy and all its employees shall not be liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the school or its employees relating to the self-administered medication by my child.

I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS.

_____ _____

Signature of *Parent or Guardian* Date

Name of Physician: _____

This student is under my care and needs to carry this medication during school hours and activities. I have given the student instructions for administration of this medication and give authorization for the self-administration of this medication. (Note: Authorization is needed for non-prescription medications, also.)

_____ _____

Signature of *Physician* Date

Address: _____

_____

Phone: _____

Note: Please place this form in student's medical file when school year is complete.

TRUEGRITS

school uniforms

11800 Sterling Ave. # K
Riverside, CA 92503
951-343-0411

Store Hours

Monday	Closed
Tuesday	10 AM - 6 PM
Wednesday	10 AM - 5 PM
Thursday	10 AM - 5 PM
Friday	11 AM - 3 PM
Saturday	11 AM - 3 PM
Sunday	Closed

Holiday Closings

Memorial Day
Fourth of July
Labor Day
Thanksgiving Weekend. Thurs – Sun
Christmas Break – Please call our store for dates

Extended hours during the summer. Please check the website or call the store for details.

Order by Phone

Using the requirement sheet, you may order by phone for delivery to your home or office. Please be ready with your Visa or MasterCard number together with the size and quantity of the items you wish to order. Shipping charges will apply.

Shop Online

www.truegrits.com Shop 24 hours a day – everyday from the convenience of your home.

Forms of Payment

In our Web Store we accept Visa or MasterCard.
At our Retail Store we accept Cash, Debit, Visa or MasterCard.

Return Policy

Garments may be returned within 90 days of purchase for Full Refund. Garments returned over 90 days from the purchase date EXCHANGES ONLY. NO REFUND or EXCHANGES for washed, worn, altered, personalized and special order garments.

Directional Map to Our Riverside Store

Note: Below you will find driving instructions, an area map and a detailed map.

Driving Instructions

- *91 Freeway Eastbound*
- Exit Pierce Street
- Right on Pierce
- Left on Sterling Avenue
- (Riverside Business Center)

- *91 Freeway Westbound*
- Exit Magnolia
- Magnolia West to Pierce
- Left on Pierce
- Left on Sterling
- (Riverside Business Center)