



# Cranium Command After-Care Program Application

Applying for School Year 20\_\_\_\_ - 20\_\_\_\_

Returning Family       New Family

## Applicant Information

Grade Level:                       Kindergarten                       First Grade                       Second Grade  
 Third Grade                       Fourth Grade                       Fifth Grade  
 Sixth Grade                       Seventh Grade                       Eighth Grade

\_\_\_\_\_  
 Last Name                      First Name                      Middle Name                      (\_\_\_\_\_) Preferred Name

\_\_\_\_\_  
 Date of Birth                       Male     Female                      Country of Origin                      Primary Language Spoken

\_\_\_\_\_  
 Address                      City                      State                      Zip Code

\_\_\_\_\_  
 Home Phone                      Alternate Phone                      Email Address

\_\_\_\_\_  
 Name of Previous School                      Dates Attended                      School Telephone Number

\_\_\_\_\_  
 Name of Previous School                      Dates Attended                      School Telephone Number

Has Applicant applied to Foundations Academies before?     Yes     No    If yes, when? \_\_\_\_\_

How did you hear about our Academies? \_\_\_\_\_

Primary hours applicant will be at the Academy:    Morning Arrival \_\_\_\_\_ am    Afternoon Departure \_\_\_\_\_ pm  
 Meals Child Will Need To Be Fed (**Infants – Primary only**):     Breakfast     Morning Snack     Lunch     Afternoon Snack

## Parent/Guardian Information

1. \_\_\_\_\_  
 Last Name                      First Name                       Mr.     Mrs.     Ms.     Dr.

Office Use Only
Pin #

Relationship to Applicant:                       Mother     Father     Other, please specify \_\_\_\_\_

\_\_\_\_\_  
 Address                       Check here if this address is applicant's residence                      City                      State                      Zip Code

\_\_\_\_\_  
 Home Phone                      Cell Phone                      Email Address

\_\_\_\_\_  
 Employer                      Position                      Business Phone

2. \_\_\_\_\_  
 Last Name                      First Name                       Mr.     Mrs.     Ms.     Dr.

Office Use Only
Pin #

Relationship to Applicant:                       Mother     Father     Other, please specify \_\_\_\_\_

**Please turn over and complete other side.**

Address  Check here if this address is applicant's residence City State Zip Code

Home Phone Cell Phone Email Address

Employer Position Business Phone

Applicant Resides With:  Both parents  Mother  Father  Other, please specify \_\_\_\_\_

Check if applicable:  Parents Married  Parents Divorced  Parents Separated  Single Parent
 Father Remarried  Father Deceased  Mother Remarried  Mother Deceased
 Applicant Adopted  Applicant in Foster Care

If parents are divorced or separated, who has legal custody of the applicant?  Mother  Father  Both
To whom correspondence should be sent to:  Both parents  Mother  Father  Other, please specify \_\_\_\_\_

\*It is the responsibility of the parent(s) and/or legal guardian(s) to provide court ordered documentation regarding custody and/or revocation of parental rights.

In the event of an emergency, and the parents listed above cannot be reached, please contact the following:

Office Use Only
Pin #
Office Use Only
Pin #

Last Name First Name Relationship to Applicant Phone Number

Last Name First Name Relationship to Applicant Phone Number

Applicant's Physicians Name Telephone Number Fax Number

Address City State Zip Code

Applicant's Dentist Name Telephone Number Fax Number

Address City State Zip Code

Has your child been tested for:

- Speech and/or hearing therapy  Psychological/Educational Assessment  Neurological evaluations
 Visual examination  Learning difference  Gifted programs

Please enclose the application fee with this form. This fee is non-refundable. Your application is regarded as a formal request for consideration of your son or daughter as a potential student at Foundations Academies. Foundations Academies welcomes and considers all applications without regard to race, religion, or ethnic or national background. Foundations Academies, Inc., 7041 Professional Parkway East, Sarasota, FL, 34240, admits students of any race, color, national and/or ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students. Foundations Academies does not discriminate in any way on the basis of race, color, national or ethnic origin in the administrations of its educational policies and/or any other school administered programs.

Applicant's Parent/Guardian Signature Date Financially responsible for applicant?  Yes  No

Office Use Only
Start Date: \_\_\_/\_\_\_/\_\_\_ Assigned Program: \_\_\_\_\_ Student PIN# \_\_\_\_\_
Date application received: \_\_\_/\_\_\_/\_\_\_ Received by: \_\_\_\_\_
Application fee paid by: \_\_\_\_\_  Check # \_\_\_\_\_  Cash  Credit Card

Foundations Academies is nationally accredited through the Southern Association of Colleges and Schools and the Florida League of Christian Schools (#15348) and is additionally licensed through Sarasota County (#58-03-01953). Foundations Academies is recognized by the Florida Department of Education as a private, non-public school (#5780).