Beacon Christian Academy

30 Prospect Ave
Bayonne, NJ 07002
201-437-5056

Fall Fundraiser Agreement and Christmas & Spring Programs Form
School Year 20__ - 20__

To keep our tuition prices down, your participation is needed in **two mandatory fundraisers.** Each family is expected to meet the $200 fall fundraiser minimum and $200 spring fundraiser minimum.

Failure to participate in any one of the two fundraisers will result in a $500.00 non-participation fee. This fee will be charged during the fundraiser period: $250.00 for the fall fundraiser and $250.00 for the spring fundraiser. As per the policy book, late fees will apply if not paid by the due date.

We appreciate your involvement and want to thank you in advance for your assistance in this endeavor. Please select one of the following options:

_☐_ Yes, I agree to participate in the school fundraisers for the year.

_☐_ No, I do not want to participate in the school fundraisers, and I will pay the additional $500 for not participating. This fee will be charged during the fundraiser period. $250.00 for the fall fundraiser and $250.00 for the winter fundraiser.

Christmas & Spring Programs

In addition, BCA has two programs a year: a Christmas and a Spring program. *Each family is required to sell 3 tickets for each play.* Each ticket is $10.00 for a total due of $30.00 for each play.

- I will receive 3 tickets (per family) for the Christmas program at a cost of $10.00 per ticket for a total due of $30.00. I will receive 3 tickets (per family) for the Spring play at a cost of $10.00 per ticket for a total due of $30.00.

- I am also aware that attendance is mandatory for my child at the Christmas and Spring Programs. If my child does not attend the play, it is considered an unexcused absence.

Child's Name: _____

Grade: _____

Parent/Legal Guardian Signature: _____

Date: _____

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_____ _____
Student's Last Name, First Name (Print) **Grade**

PICK-UP AUTHORIZATION FORM
SCHOOL YEAR 20__ - 20__

I hereby authorize Beacon Christian Academy to release my child(ren) to the following individuals: (PLEASE PRINT. MUST INCLUDE FIRST & LAST NAME.)

Name	Phone #

***Any person picking up your child must have a DRIVER'S LICENSE or STATE ID with the date of birth and be at least 18 years old. ***

Please do not be offended if asked for identification, as aftercare staff sometimes rotate. This is for the safety of your child.

I understand that if the name does not appear on the list, my child will not be released from school.

_____ _____
Parent/Legal Guardian Signature Date

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Permission To Go Outdoors
School Year 20__ - 20__

Beacon Christian Academy would like to take every opportunity possible to take the children outdoors. When the weather permits, the staff may want to take the children outside to play. Additionally, we use our building at 100 East 22nd Street for different functions (i.e., chapel, play practice, before care).

Please fill out the form below to allow BCA staff to take your child outside during the school day or during before/aftercare.

☐ Yes, please allow my child to go on all outdoor activities during the school day at Beacon Christian Academy.

☐ No, I prefer that my child do not go outdoors during the school day.

Name of Child: _____ Grade: _____

Signature of Parent/
Legal Guardian: _____ Date: _____

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Photography Consent Form
School Year 20__ - 20__

Throughout the school year, photographs are taken of students during school-related activities and events. The photographs of students may include, but are not limited to, school programs, school marketing materials and advertisements, school announcements, and school events.

Please note, however, that the Opt-out provision below shall not apply to school-related programs and events that are open to the public (i.e., school plays/musicals, sports events, graduations, etc.)

Please check one of the boxes below:

☐ Yes, my child's picture can be taken.

☐ No, I opt out of having my child's picture taken.

Child's Name: _____ Grade: _____

Parent's Name: _____

Parent's Signature: _____ Date: _____

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Consent for Emergency Medical Treatment and Allergy Information
School Year 20__ - 20__

Date_____

Child's Name_____ DOB: _____

Special Medical Information You Want Us to Know About:

_____

Allergies: _____

I, Parent/Legal Guardian of _____, read and understand the Emergency/First Aid Procedures as stated in the Parent Handbook, and consent to the procedures described.

I authorize the Principal of Beacon Christian Academy, or such staff members or licensed physicians as may from time to time be designated, to perform first aid procedures in the event of injury or illness of my child.

In case of a major accident, injury or illness requiring immediate medical or surgical care, I further authorize said persons to stabilize the child and to act on my behalf, provided that they first make such effort as the nature of the emergency permits to notify me, or if I am unavailable, the following person can be contacted:

_____

Name (Other than Parent/Legal Guardian) Relationship to Child Phone #

Whom I hereby also authorize to act on my behalf in the situation and obtain my (or his/her) preferences. If such efforts to contact my representative designated above or me are unsuccessful, I authorize the Director and/or Staff members of Beacon Christian Academy to arrange to transport my child to the nearest local hospital Emergency Center and to secure for my child any medical treatment deemed necessary or appropriate by any licensed practitioner. I also agree to reimburse those persons acting hereunder for any cost or expenses which are incurred on my behalf or on behalf of the child regarding any medical attention sought for the child.

Parent/Legal Guardian Signature: _____ Date: _____

Pediatrician's Name & Phone Number: _____

City/State: _____

***PLEASE PROVIDE A COPY OF THE CHILD'S INSURANCE CARD (FRONT AND BACK). ***

Catapult Learning

Medication Authorization During School Hours

DOCTOR FILLS IN REQUIRED SECTIONS. Parents sign and return completed form to the school nurse. This form is required for over-the-counter or prescription medication administered in school. Please do not make any changes to this form

STUDENT: _____ GRADE: _____

DATE OF BIRTH: _____ HOME PHONE: _____

Medication taken at home YES: _____ NO: _____

Name of Medication(s) taken at home: _____

_____

The following **prescription medication** may be administered to my patient:

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR: _____

SIGNIFICANT SIDE EFFECTS: _____

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR: _____

SIGNIFICANT SIDE EFFECTS: _____

The following **over-the-counter medication(s)** may be administered to my patient:

Cough Drop: _____ How frequently: _____ As needed for: _____

Tylenol: 325 mg _____ How many: _____ How Frequently: _____
OR 160 mg _____ How many: _____ How Frequently: _____
As needed for: _____

Motrin/Advil: 200 mg _____ How many: _____ How frequently: _____
OR 100 mg _____ How many: _____ How frequently: _____
As needed for: _____

Benadryl: Dosage: _____ How frequently: _____ As needed for: _____

Doctor Name (print): _____ Date: _____

Doctor Signature: _____ **Doctor Stamp**:

I request for my child, _____, to receive medication as listed above. I have been informed that the school, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child.

Parent Name (print): _____ Date _____

Parent Signature: _____

Return this form only if you want to authorize medication administration