Registration Checklist
2025 - 2026 School Year

Please use this checklist to confirm that you have turned in all required documents on or before August 28th. Forms may be turned in by mail, dropping them off at the upper school office, or emailing copies to natalie.simmons@bradfordchristianacademy.org at the lower school or nicole.dole@bradfordchristianacademy.org at the upper school.

1. Emergency Information Form
2. Home Language Survey (new students only)
3. BCA Policy Agreement and Permission Form
4. Approval for Administration of Discretionary Medication
5. BCA Annual Student Required Forms
   - ☐ Proof of Age (birth certificate or passport) (new students only)
   - ☐ Student Immunization Record
   - ☐ Most recent physical exam record at the start of the school year as follows: All new students, students entering grades 4, 7, or 10, and all high school athletes.
   - ☐ Concussion Form (high school athletes only)
   - ☐ School Records (new students only)
   - ☐ Discipline Report (new students only)

Additional Documentation - If Applicable

- ☐ Food Allergy Action Plan
- ☐ After School Program Registration (K-5) (6-8)
  Please note, any student in grades K-5 not picked up by 3:00 p.m. and any student in grades 6-8 not picked up by 3:30 p.m. will be put into the after school program and parents will then be billed accordingly.
- ☐ Prescription Medication Permission Form
- ☐ Guardianship Papers For Caregiver Authorization Affidavit
- ☐ Copy of the Student's IEP or 504 Plan.
- ☐ Concussion Form

Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

Student Information

First Name _____ **Middle Name** _____ **Last Name** _____

Country of Birth _____ **Date of Birth** (mm/dd/yyyy) ____/____/____ **Date first enrolled in ANY U.S. school** (mm/dd/yyyy) ____/____/____

School Information

Start Date in New School (mm/dd/yyyy) ____/____/20____ **Name of Former School and Town** _____ **Current Grade** _____

Questions for Parents/Guardians

What is the primary language used in the home, regardless of the language spoken by the student? _____	**Which language(s) are spoken with your child?** (include relatives -*grandparents, uncles, aunts,etc.* - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
What language did your child first understand and speak? _____	**Which language do you use most with your child?** _____
How many years has the student been in U.S. Schools? (not including pre-kindergarten) _____	**Which languages does your child use? (circle one)** _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always
Will you require written information from school in your native language? **Y** ☐ **N** ☐ **If yes, what language?** _____	**Will you require an interpreter/translator at Parent-Teacher meetings?** **Y** ☐ **N** ☐ **If yes, what language?** _____
Parent/Guardian Signature: **X**	____/____/20____ **Today's Date:** (mm/dd/yyyy)

BCA Policy Agreement & Permissions Form 2025-2026

Student Handbook Agreement

We have read and agree to abide by all of the principles, policies, and procedures stated in Bradford Christian Academy's Parent-Student Handbook.

Upper School Uniform Policy: We have read and agree to abide by the upper school uniform policy in Bradford Christian Academy's Parent/Student Handbook. (Grades 6-12 only) Initial_____

Acceptable Use Policy Agreement Form: By signing this form, members of the BCA community demonstrate that they understand the Acceptable Use Policy for Technology as stated in the Parent-Student Handbook and agree with its terms. Our family has read and fully accepts the community standards outlined in BCA's Acceptable Use Policy.
Initial_____

Parent Signature: _____ Print Name: _____ Date: _____

Student Signature: _____ Print Name: _____ Date: _____

Photo Permission

On occasion, BCA will feature students on their Facebook and Instagram channels or be featured in local news media. It is the policy of BCA to not allow any child to be photographed without prior permission from the parents of the child. Furthermore, it is the policy of BCA to not allow the public publishing of any child's name in an article or associated with a photograph that is included in an article without prior permission from the parents of the child.

□ I give Bradford Christian Academy permission to allow my child(ren) to be photographed during Bradford Christian Academy events, programs, and other special interests.

____Yes, my child(ren)'s name can be published in local or social media
____No, my child(ren)'s name can not be published in local or social media

□ I DO NOT WISH to have my child(ren) photographed during Bradford Christian Academy events, programs, and other special interests, and my child(ren)'s name should not be published in local or social media

Initial_____

Transportation Permission

Your signature on this form gives your permission and authorizes BCA to transport students during the school year for BCA related events. Some examples are: Between campuses, Ward Hill Church, First Church of Christ, neighborhood walking field trips, and sporting events. Other locations may be used. Parents will be told in advance if we plan to move students.

Field Trip Permission Forms will be sent home during the school year for each field trip as it is scheduled.

Parent Signature: _____ Print Name: _____ Date: _____

Approval of Administration of Discretionary Medications
2025 - 2026

Name: _____

Date of Birth: _____Grade:_____

Allergies/Sensitivities_____

_____

Current Medications (including inhalers) (please also complete a prescription medication form)

_____

_____

Medical Conditions_____

The following medications may be dispensed at the School Office's discretion for the temporary relief of discomfort associated with a cold, headache, dental discomfort, muscular aches, fever, sore throat, upset stomach, coughs, cuts, and scrapes.

Please check any medication you wish to be made available to your child:
I understand that the generic equivalent of medications may be used.

Medication	**Dosage**		
_____***Acetaminophen (like Tylenol 325mg)***	____***2 tablets***	____ ***3 tablets***	***(Every 4 hours)***
_____***Ibuprofen (like Advil 200 mg)***	____***2 tablets***	***(Every 4 hours)***	
_____Chewable antacid (i.e. Tums)	1-2 tabs		
_____Cough Drops			
_____Hydrocortisone 1%			

I understand that the above medications I have checked will be administered by the school office.

____ *I give permission for my child to be given the above checked medications in school.*

____ *I do not want any medication given to my child in school.*

_____ _____
Signature of Parent/Guardian Cell Phone

Food Allergy Action Plan

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

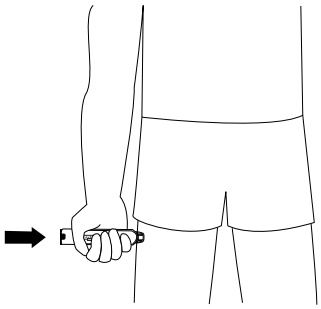
TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

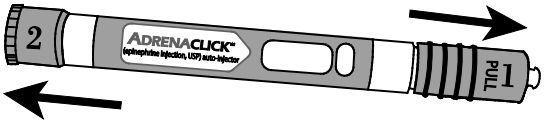
SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_____) Doctor:_____ Phone: (___)_____-_____
Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts
Name/Relationship: _____ Phone: (___)_____-_____
Name/Relationship: _____ Phone: (___)_____-_____

BRADFORD CHRISTIAN ACADEMY

After School Program Registration

Bradford Christian Academy offers after-school supervision Monday through Thursday for students in grades K through 8 led by BCA faculty and staff.

Homework Club for students in grades K-5 includes homework help so that students may complete their homework before going home. Homework Club operates between 3:00 and 4:30 Monday through Thursday. The cost is $20 per student per day or $2,500 for the year (a 25% discount).

Late Day Pick-Up for students in grades 6-8 offers supervision to ensure safety and wellbeing and operates Monday through Thursday from 3:30 to 4:30 The cost is $10 per student per day or $1,200 for the year (a 25% discount).

Parents who decide to sign up their student for the year have the option to pay in one payment in September or two payments–the first in September and the second January. Parents choosing to pay per day will be invoiced monthly. Families with two or more months outstanding invoices will not be allowed to continue to use the program until the balance is paid.

Parents must pick their student(s) up by 4:30 pm. **An additional $20 per student will be charged for students picked up after 4:30 pm.**

Please note, any student in grades K-5 not picked up by 3:00 p.m. and any student in grades 6-8 not picked up by 3:30 p.m. will be put into the after school program and parents will then be billed accordingly.

To sign up for either program, please complete the registration form and accept the terms and conditions by signing your name. The form should be submitted to the main office of your student's building. Once we receive a completed form, your student may begin participating in after-school care. You or your student must sign in and out of the homework club each time he or she uses the program.

Student Name: _____Grade: _____
Parent/Guardian Name: _____
Parent/Guardian Contact Numbers:
Home: _____ Cell: _____ Work: _____

If you wish to authorize other individuals to pick up your child, please provide their contact information below:

Name & Relation: _____
Contact Numbers:
Home: _____ Cell: _____ Work: _____

Payment Options

I would like the following payment option:
Homework Club
___ Per day, as needed ($20/day) If you select this option please let the main office at your child's school know he or she will be staying for Homework Club no later than 9:00 a.m.
___ Entire School Year: ($2,500 in full)
___ Two Payments: ($1,250 due in September & 1,250 due in January)

Late Day Pick-Up (6 through 8)

___ Per day, as needed ($10/day) If you select this option please let the main office at your child's school know he or she will be staying for Late Day Pick-Up no later than 9:00 a.m.

___ Entire School Year: ($1,200 in full)

___ Two Payments: ($600 due in September & $600 due in January)

BRADFORD CHRISTIAN ACADEMY

PARENT/GUARDIAN AUTHORIZATION
FOR PRESCRIPTION MEDICATION 2025-2026

Please fill out all areas. Form must be completed by the Parent or Guardian.

I request that my child _____ receive the medication prescribed in the form below by his/her physician _____ Date:_____
Address_____ Telephone #_____
Parent/Guardian Signature:_____

This portion is to be filled out by the
PRESCRIBING PHYSICIAN

I request that my patient receive the following medications:

Name of Student_____
Diagnosis_____

Medication_____
Prescribed Dosage_____
Route of Administration_____ Frequency _____ Times _____

Medication_____
Prescribed Dosage_____
Route of Administration_____ Frequency _____ Times _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Expected Duration of Treatment: _____

Possible Side Effects and Adverse Reactions:_____

Other Recommendations _____

Physician's Name _____

Telephone #_____

Physician's Address_____

Physician's Signature_____ **Date:**_____

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
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Tel: 617-624-6000
www.mass.gov/dph

Pre-Participation Head Injury/Concussion Reporting Form for Extracurricular Athletic Activities

This form should be completed by the student's parent(s) or legal guardian(s). Please submit this form to the Athletic Director, or Official designated by the school, prior to the start of each season a student plans to participate in an extracurricular athletic activity.

Student's name	Sex	Date of birth	Grade
School name	Sport(s)		
Home address	Phone number		

Has student ever experienced a traumatic head injury (a blow to the head)? Yes_____ No_____ If yes, when? Dates (month/year):
Has student ever received medical attention for a head injury? Yes_____ No_____ If yes, when? Dates (month/year): If yes, please describe the circumstances:
Was student diagnosed with a concussion? Yes_____ No_____ If yes, when? Dates (month/year):
How long did symptoms last for the most recent concussion? (i.e., headache, difficulty concentrating, fatigue)

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date:_____

Athlete Name: _____

Athlete Signature: _____ Date:_____