



Registration Checklist
2026-2027 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 (RETURNING & NEW STUDENTS)
2. Home Language Survey (**new students only**)
3. BCA Policy Agreement and Permission Form (RETURNING & NEW STUDENTS)
4. Approval for Administration of Discretionary Medication (RETURNING & NEW STUDENTS)
5. BCA Annual Student Required Forms (RETURNING & NEW STUDENTS)
 - 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.
 - School Records (**new students only**)
 - Discipline Report (**new students only**)

Additional Documentation - **IF APPLICABLE**

- Allergy Action Plan- (if require an EPI Pen/Inhaler or other meds)
- After School Program Registration (K-5)
Please note, any student in grades K-5 not picked up by 3:00 p.m. will be put into the after school program and parents will then be billed accordingly- ALL STUDENTS - K THROUGH 12 MUST BE PICKED UP BY 4PM!
- Prescription Medication Permission Form (if require prescription meds in school)
- Copy of the Student's IEP or 504 Plan
- Concussion Form (**high school athletes only**)



BCA Policy Agreement & Permissions Form 2026-2027

Student Handbook Agreement

We have read and we 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: _____

Home Language Survey-FOR NEW STUDENTS ONLY

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

Today's Date: _____ / _____ /20 _____
(mm/dd/yyyy)

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History

Pertinent Family History

Current Health Issues

Y **N**
 Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi -Pen®: Yes No
 Asthma: Asthma Action Plan Yes No (Please attach)
 Diabetes: Type I Type II
 Seizure disorder: _____
 Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination

Date of Examination: _____

Hgt: _____ (____%) Wgt: _____ (____%) BMI: _____ (____%) BP: _____

(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

Laboratory Results: Lead _____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

TB Test Type: TST IGRA Date: _____ Result: Positive Negative Indeterminate/Borderline

Referred for evaluation to: _____ Date: _____ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations: _____

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

Y N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date _____

Please print name of Examiner.

Group Practice _____

Telephone _____

Address _____

City _____

State _____

Zip Code _____

Please attach additional information as needed for the health and safety of the student.

MDPH 08/15/13

**Confidential Student Emergency Information Form
2026-2027 School Year**



Student Name (First, Middle, Last): _____

Grade: _____ Date of Birth: _____ Place of Birth: _____

Home Telephone: _____ Student Cell Phone: _____

Address: _____

Race (for State Reporting Purposes): American Indian ___ Asian ___ Black ___ Hispanic ___ White ___

Emergency Phone Numbers:

Mother's Name: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Father's Name: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Student Lives with Both () Father () Mother ()

Please indicate if there are any parental restrictions:

Name, address, and phone number of person to be contacted if parents are not available

Name: _____ **Relationship:** _____

Address: _____ **Telephone:** _____

Medical Release:

We/I, the parent(s)/guardian(s) do hereby authorize the staff of Bradford Christian Academy, to act on our/my behalf in the event that our/my child named above requires medical attention of any kind and we/I cannot be reached.

BCA is hereby authorized to take whatever steps may reasonably be necessary to secure adequate medical attention for our/my child named above. BCA may release physicians and/or other medical personnel to perform any and all medical procedures or to take any other measures deemed necessary and appropriate to affect such treatment, under the circumstances.

We/I agree to bear full responsibility for any costs or obligations incurred by BCA in providing medical care for our/my child.

Pediatrician: _____ Phone: _____ Location (town/city only): _____

Health Insurance Carrier: _____ ID#: _____

Has your child had a physical within the last two years? Yes () No () Date of last physical: _____

*Please have your physician fill out the attached medical form with updated vaccinations or send in the physician's form.

*High school students are required to have an updated physical upon entering ninth grade.

*High school athletes are required to have a physical yearly and complete concussion forms. See attached sheets.

Please list medications taken on a regular basis (name and dose) _____

Medication allergies: _____

List any chronic health problems your child may have such as eye/ear problems, heart disease, diabetes, seizure disorders, asthma, etc.

Allergies

Our child has the following allergies (please list allergies. If your child has no known allergies, please write 'N/A' in the space below):

Signature of Father: _____ Signature of Mother: _____ Date: _____



BRADFORD CHRISTIAN ACADEMY

**PARENT/GUARDIAN AUTHORIZATION
FOR PRESCRIPTION MEDICATION 2026-2027**

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:** _____



BRADFORD CHRISTIAN ACADEMY

Approval of Administration of Discretionary Medications 2026 - 2027

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%		

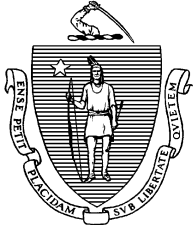
I understand that the above medications I have checked will be administered by the school office.

____ 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



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
 Governor

KIMBERLEY DRISCOLL
 Lieutenant Governor

KATHLEEN E. WALSH
 Secretary

ROBERT GOLDSTEIN, MD, PhD
 Commissioner

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: _____



AFTER SCHOOL PROGRAM REGISTRATION FORM

Homework Club and After-School Supervision

Bradford Christian Academy offers **Homework Club**, an after-school program for students in **Kindergarten through Grade 5**, Monday through Thursday. The program is supervised by BCA faculty and staff and provides students with a structured environment in which to complete homework and receive academic support.

Hours and Fees

Homework Club operates from dismissal until **4:00 p.m.**

- Daily Rate: **\$20 per student, per day**
- Annual Rate: **\$2,500 per student** (a 25% discount from the daily rate)

Students enrolled in Homework Club should be picked up no later than **4:00 p.m.**

A **\$20 late fee per student** will be charged for any student who is picked up after 4:00 p.m.

Any student in Grades K–5 who has not been picked up by 3:00 p.m. will be placed in Homework Club and the family will be billed accordingly.

Grades 6–12

Students in Grades 6–12 are expected to leave campus at the end of the school day unless they are participating in a school-sponsored activity, such as athletics, fine arts, a club, or a meeting with a teacher.

While Bradford Christian Academy does not offer an after-school program for students in Grades 6–12, school staff remain on campus until 4:00 p.m. Should an occasional need arise for a student to remain briefly after dismissal, parents should communicate with the school in advance to make appropriate arrangements.

Students who are not participating in a supervised school activity should be picked up no later than 4:00 p.m.



BRADFORD

CHRISTIAN ACADEMY

Registration and Sign-Out

To sign up for Homework Club, please complete the registration form and accept the terms and conditions by signing your name. The form should be submitted to the main office at the lower school. Once we receive a completed form, your student may begin participating in Homework Club. You must sign your student 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 & Relationship to student: _____

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)

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 _____

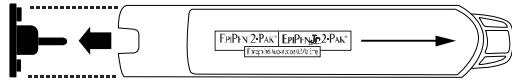
Date _____

TURN FORM OVER

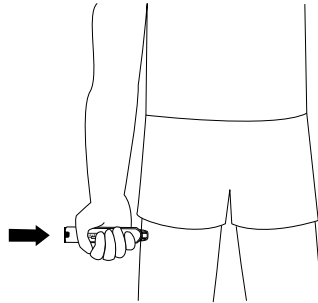
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

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



DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

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: _____
 Parent/Guardian: _____

Phone: (____)_____-_____
 Phone: (____)_____-_____

Other Emergency Contacts

Name/Relationship: _____
 Name/Relationship: _____

Phone: (____)_____-_____
 Phone: (____)_____-_____