

**ADMISSION INFORMATION**

Operation Name: First Christian Day School (FCDS)      1109 Brown St.      Waxahachie, TX 75165

Child's Full Name:      Child's Date of Birth      Child's Home Telephone No.

Child's Home Address:

Date of Admission :      Date of Withdrawal:

Parent's or Guardian's Name:      Address:

List telephone numbers & email address below where parents/guardian may be reached while child is in care:

Mother's (work and cell)      Father's (work and cell)      Guardian's (work and cell)

Email:      Email:      Email:

Student's Physician      Name:      Telephone No.

Address:

Hospital      Name:      Telephone No.

Address:

Student's Insurance      Carrier:      Group:

Name Insured:      Insured's employer:

Student allergies or  
Medical conditions:

Medications taken by student:

**EMERGENCY MEDICAL TREATMENT PERMISSION & HOLD HARMLESS & INDEMNITY**

Give the name, address and phone number of person to call in case of emergency if parents/guardian cannot be reached.      Relationship

If my child needs emergency medical treatment while in the care of First Christian Day School (FCDS) and if FCDS is unable to reach me or my Emergency contact, I authorize FCDS or person in charge to give consent to any necessary emergency treatment or care. I RELEASE, HOLD HARMLESS, & INDEMNIFY FCDS AND ITS REPRESENTATIVES FROM ANY LIABILITY FOR SUCH TREATMENT OR CARE.

**MEDICATION PERMISSION & HOLD HARMLESS & INDEMNITY**

I authorize FCDS to administer prescription medications to my child when I send them. Such medication will be sent in a zip lock bag (with child's name written on the outside). All such medication must be in original container with child's name, date filled, dosage instructions and physician's name. I also authorize FCDS to administer non-prescription medication to my child when I bring them (such medication must be in original container with dosages for my child's age and/or weight indicated). I will leave written instructions as to dosage and time that any medication is to be given. I will bring all medication to the school's Front Office, not placed in my child's belongings. I authorize FCDS to administer routine First Aid to my child and I understand FCDS will call me or send home a note if FCDS does so. I RELEASE, HOLD HARMLESS, & INDEMNIFY FCDS AND ITS REPRESENTATIVES FROM ANY LIABILITY FOR ADMINISTERING MEDICATION TO MY CHILD. I give permission for school staff to give the following over-the counter medication as per label directions (CIRCLE AS APPLICABLE) after first calling me.

Tylenol/Acetaminophen      Advil/Ibuprofen      Benadryl/Antihistamine      Tums/Antacid      Cough Drops

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ 20\_\_

**STUDENT NAME:**

**PARENTS AS PARTNERS**

I understand that FCDS may at any time perform a criminal background check on parents/guardians of enrolled children (or other persons designated and approved by FCDS to help with Parents as Partners. Listed below are each person's full name (first, middle, last) any alias or maiden name used within the last 5 years, driver's license number, date of birth, and county & state of residence during last 5 years.

Full Name (1 <sup>st</sup> , middle, last)	Date of Birth	Driver's License & Social Security #s	County & State	last 5 yrs.	Alias/Maiden names –last 5 yrs
Father/Guardian		DL#	State		
		SS#			
Mother/Guardian		DL#	State		
		SS#			
Other Designated Person		DL#	State		
		SS#			

**PERSONS AUTHORIZED FOR CHILD PICK UP**

I hereby authorize First Christian Day School to allow my child to leave the school premises ONLY with the following persons. Please list name & phone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification with photo ID.

NAME	PHONE NUMBER	DRIVER'S LICENSE NUMBER & STATE

**PERSONS *NOT* AUTHORIZED FOR CHILD PICK UP**

The person(s) listed below are NOT authorized to pick up my child from school (note: written court orders denying a parent access to a child must be on file with FCDS), and I agree to keep this list current. The school will make reasonable efforts to refuse such pick-ups. I RELEASE, HOLD HARMLESS & INDEMNIFY FCDS AND ITS REPRESENTATIVES FROM ANY LIABILITIES PER THIS AUTHORIZATION.

Name	DL#	Name	DL#

**Learning & Conduct History:**

Please answer each question for Applicant. If you answer "Yes" to any questions, please use the space to the right to explain. Attach additional sheets if needed. Attach copies of diagnostic reports & other supporting documentation.

Trouble with attention or focus?	_____ No	_____ Yes
Trouble with hyperactivity?	_____ No	_____ Yes
Diagnosis of or ever been informed of suspected ADD/ADHD?	_____ No	_____ Yes
Trouble with reading, math or other academic area?	_____ No	_____ Yes
Ever been enrolled in speech, occupational, or physical therapy?	_____ No	_____ Yes
Ever been considered for or enrolled in school intervention services (e.g., language, dyslexia, special ed., reading recovery, RTI, PPCD, etc.?)	_____ No	_____ Yes
Assigned in a special program due to misconduct, poor attitude, Or similar conduct	_____ No	_____ Yes
Misconduct in school or otherwise, past or present?	_____ No	_____ Yes
Discipline or attitude difficulties past of present?	_____ No	_____ Yes
Out of school or in school suspension, asked to leave school or Detentions.	_____ No	_____ Yes

**STUDENT NAME:**

**IMMUNIZATION RECORD**

- I have provided FCDS with a copy of my child's most current immunization record.
- I am excluding my child from the immunization requirements for reasons of conscience, including religious belief. I have attached an official Notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_

**HEALTH CARE STATEMENT**

One of the following must be presented when your child is admitted to FCDS or within one week of admission.

1.  **HEALTH CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he/she is able to take part in First Christian Day School's program.

\_\_\_\_\_ Date \_\_\_\_\_ 20\_\_

**Health Care Professional's signature**

2.  A signed and dated copy of a health care professional's statement is attached.
3.  Medical diagnosis and treatment conflict with the tenets and practices of recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
4.  My child has been examined within the past year by a health care professional and is able to participate in FCDS's program. Within 12 months of admission. I will obtain a health care professional's signed statement and will submit it to FCDS's operation.

NAME of Health Care Professional: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ 20\_\_

**Previous Daycare Information (if any)**

Daycare attended	City, State	Date Attended	Reason for leaving

**School attended** --- Before admission can be completed, FCDS must receive a copy of current and prior school records covering at least the last two years of attendance (including assessment scores, report cards, special placement information, diagnostic testing, etc.) Failure to provide this information could result in student dismissal.

School Name (most recent first)	City, State	Date Attended	Grades Completed

**Church Attended:** \_\_\_\_\_ **Address:** \_\_\_\_\_

I will promptly update the above information if any changes occur.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_ 20\_\_

Statement of Nondiscrimination: FCDS admits students of any race, color, national & ethnic origin to all the rights, privileges, program, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national & ethnic origin in administration of its educational policies, admissions policies, and any other school administrated programs.