WELCOME TO

Touching lives today for Eternity . . .

RE-ENROLLMENT PACKET

Then you will understand what is right, just, and fair,
. . . for wisdom will enter your heart, and
knowledge will fill you with joy.
Proverbs 2:9-10 NLV

1600 Boca Chica Blvd. Brownsville, TX 78520 Tel: (956) 542-4854 Fax: (956) 542-6188 www.fbscrusaders.net

First Baptist School Family

Thank you for your continued interest in First Baptist School. We know that you have many choices for the education of your children; therefore, we are delighted that you are entrusting us with this opportunity. Know that we do not take this privilege lightly. Rest assured that our dedicated staff and faculty will do their utmost to ensure the success of your student. Your participation is crucial. As we trust in the Lord, we are looking forward to serving you and your family.

Please fill out your application completely. Only completed applications with updated immunization records, will be processed.

Good communication will greatly enhance our ability to be effective. Our primary and official source of communication is by e-mail. Therefore, each family is required to have a current e-mail address on file in the school office. I would encourage you to ensure that you maintain current email and cell phone numbers with the school as they are also used in case of emergency.

A capital improvement fee is attached to your account as we are constantly attempting to improve our campus with new construction as well as remodeling.

We are here to serve you and consider it a joy and a privilege to do so. However, volunteers play a vital role in the success of our school. Our army of volunteers helps to keep tuition low and puts "icing" on the cake. Let the school office know if you are interested in this wonderful opportunity.

We pray that God will bless you and your family.

Serving Him,
Terry A. Roberts
Superintendent

First Baptist School is committed to glorifying God by providing a biblically-based education so that students are transformed and equipped to meet the challenges of post-secondary education and career advancement, while serving and impacting the world for the Kingdom of Christ.

FIRST BAPTIST SCHOOL RESERVES THE RIGHT TO REQUEST THE WITHDRAWAL OF ANY STUDENT WHO DOES NOT MEET ACADEMIC REQUIREMENTS OR FAILS TO CONFORM TO ITS RULES AND POLICIES.

First Baptist School is fully accredited by the Association of Christian Schools International (ACSI) and Southern Association of Colleges and Schools (SACS) and does not discriminate on the basis of race, national or ethnic origin, gender, age or disability in its admissions policies or access to its educational, and extracurricular programs and activities.

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RE-ENROLLMENT APPLICATION

2018-2019

Date of Application: _____
Student is applying for: _____ **Grade**
School year: 20 - 20

STUDENT'S FULL LEGAL NAME: _____
Last First Middle Called

Home/Mailing address: _____ Phone Number: (_____)_____
Street/PO Box

_____ _____
Student's email address City State Zip

FATHER'S NAME: _____

Address _____
Street

_____
City State Zip

Home Phone No. (____)_____

Cell Phone No. (____)_____

Preferred language for correspondence: English /Spanish

E-MAIL _____

OCCUPATION/TITLE _____

Name of Business _____

Address _____
Street

_____
City State Zip

Work Phone No. _____

Fax No. _____

Other contact _____

MOTHER'S NAME:_____

Address _____
Street

_____
City State Zip

Home Phone No. (____)_____

Cell Phone No. (____)_____

Preferred language for correspondence: English /Spanish

E-mail _____

OCCUPATION/TITLE _____

Name of Business_____

Address_____
Street

_____
City State Zip

Work Phone No. _____

Fax No. _____

Other contact _____

Please choose a tuition payment plan.

____ **Annual Payment ($120 discount for families who pay tuition and fees by July 31, 2018)**

____ **10 month payment plan (August thru May) (First payment is due on August 1, 2018)**

All books and fees due by July 1, 2018

WILL THE STUDENT BE ATTENDING EXTENDED CARE SERVICES*? ___Yes ___No

____ Before School (**7:30-8:00 am**) ____ After School **(3:30 – 5:15 pm**)

***ALL ELEMENTARY STUDENTS ARRIVING BEFORE 8:00 AM AND/OR REMAINING AFTER 3:45 PM ARE REQUIRED TO BE IN EXTENDED CARE**

For Office Use Only

Re-enrollment Fee _____ **Cash or Check #** _____ **Date** _____

RenWeb #_____

STUDENT INFORMATION AND EMERGENCY MEDICAL FORM

STUDENT'S NAME _____ DATE OF BIRTH _____GRADE _____

In the event that I/we cannot be reached to make arrangements for emergency medical attention, the administration/faculty of First Baptist School should contact the persons listed below who have authorization to secure medical attention for my child. In the unlikely event that these persons are unavailable, I/we authorize the school personnel to contact the licensed physician listed below for medical advice and, if necessary, to transport my child to the physician's office or whatever medical treatment facility s/he recommends. In the event the physician is unavailable or unwilling to give direction to the school personnel, they also have my/our authorization to use their professional discretion to secure the best available medical attention for my child.

First Baptist School DOES NOT ASSUME any responsibility in case of accident or injury. I do hereby agree to indemnify and hold harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of this student. If between this date and the beginning of school any illness or injury should occur that might limit this student's participation in any activities, or if there is a change in status during the school year, I agree to notify the school authorities.

AT LEAST ONE EMERGENCY CONTACT, IN ADDITION TO THE PARENTS, IS REQUIRED FOR EACH STUDENT.

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL

MEDICAL FACILITY/PERSONNEL

Physician's name _____ Phone (___) _____

Address_____

City *State* *Zip*

Other preferred medical treatment facility or contact:_____ Phone (___)

Address_____

City *State* *Zip*

Special medical information/instructions or comments:

_____

_____

MAJOR MEDICAL INSURANCE INFORMATION

Company _____ Policy Holder: _____

Policy # _____ Group # _____ Phone _____

ALLERGIES *Please circle any which apply to your child:*

PENICILLIN ASTHMA/HAY FEVER SUNBURN SENSITIVITY INSECTS OTHER:_____

TREATMENT PROCEDURES, SHOULD THE CHILD DISPLAY AN ALLERGIC REACTION:

_____

_____

OTHER INFORMATION

At times, students complain of common discomforts – headaches, sore throats or stomach aches. **Please circle which items the school may administer to your child**. *Without your permission these medications will not be administered.*

TYLENOL **COUGH DROP** **ANTACID TABLET**

Does your child wear: Glasses _____ Contact Lenses:_____ Hearing Aids _____

PICK-UP INFORMATION : The following may pick this student up from school:

NAME	RELATIONSHIP	PARENT INITIALS

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ABOVE AND ON THE PREVIOUS PAGE IS TRUE AND ACCURATE.

Father's signature _____ Date _____

Mother's signature _____ Date _____

Legal Guardian's Signature _____ Date _____

CONTRACTUAL AGREEMENTS SCHOOL YEAR 20__- 20___

STUDENT'S NAME: _____GRADE: _____

FINANCIAL AGREEMENT

I understand that…
Payments are to be made on a 10-month (Aug. – May) plan, unless annual or semi-annual payment arrangements are made. Payments are due on the 1st of each month and are considered delinquent after the 10th. Fees are due by July 1 and considered late on the 10th.

At that time, a 10% late fee will be added to the balance of my account.
If my first payment is not made by August 10th, my child's name may be replaced by someone on the waiting list.

First Baptist School does not issue refunds on registration fees or initial tuition **payments**.

If my account is delinquent and prior arrangements have not been made with the administration, my child will not be allowed to participate in any extra-curricular activities until tuition is paid and my child is subject to removal from the school.

REPORT CARDS will not be issued until all accounts are paid in full.

PARTICIPATION AGREEMENT

My child has permission to participate in all school activities, including bus trips, sports activities, and school-sponsored trips away from the school premises. I also grant permission to FBS and its staff to photograph, videotape, or audiotape me, my child/ ward and to copyright, use and/or publish the photographs/videotapes and audiotapes in any school publication or public relations related material.

We agree to attend the parent meetings during the school year, as well as Open House or Parent Conferences.

STATEMENT OF COOPERATION

I agree that if my child is enrolled at First Baptist School, I will do my utmost to cooperate with and support the school in its methods and principles of education. **I have read the Parent-Student Handbook and agree to support the policies therein.**

SIGNATURES: BOTH PARENTS MUST SIGN

I CERTIFY THAT THE INFORMATION GIVEN ON THIS APPLICATION IS FACTUAL AND TRUE. I UNDERSTAND THAT FALSIFYING INFORMATION CONTAINED IN THIS APPLICATION MAY BE CAUSE FOR IMMEDIATE DISMISSAL.

Father's signature _____ Date _____

Mother's signature _____ Date _____

Legal Guardian's Signature _____ Date _____

Federal Programs Qualification Form 2018-2019

The Brownsville Independent School District Federal Programs welcomes the opportunity to assist and support First Baptist School with additional reading and math labs.

In order to determine whether or not your student is eligible, please complete the following survey.

Find your family size and look at the annual gross income level beside it on the chart printed below.

HOUSEHOLD SIZE	***ANNUAL INCOME***
1	***22,311***
2	***30,044***
3	***37,777***
4	***45,510***
5	***53,243***
6	***60,976***
7	***68,709***
8	***76,442***

Is your family income less than the amount on the chart? _____yes _____no

Please provide the following information:
Name of student (s): _____

Address: _____

Public School your student (s) is zoned for with BISD: _____

Grade Levels of your student (s): _____

First Baptist School
Physical Examination Form

School Year _____

Grade:_____

Both sides of this form must be completed, and turned in to the school office before your student is allowed to participate in any athletic activity, including P.E.

Student's Name _____ Gender _____ Age _____ Date of Birth _____
Height _____ Weight _____ Pulse _____ Blood Pressure _____
Vision: R – 20/ ___ L – 20/ ___ Corrected: yes no Pupils: Equal _____ Unequal _____

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/ears/nose/throat			
Lymph nodes			
Heart – auscultation of the heart in the supine position			
- auscultation of the heart in the standing position			
- pulses (all extremities)			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
foot			

Station-based examination only

Medical History Questionnaire - to be completed by the physician

1.	Is the patient under a doctor's care for a specific medical condition?	**Yes**	**No**
2.	Has the patient been hospitalized overnight in the past year?	**Yes**	**No**
3.	Has the patient had surgery in the past year?	**Yes**	**No**
4.	Is the patient currently taking any prescription or over-the-counter medications?	**Yes**	**No**
5.	Has the patient ever experienced any complications during or after exercise?	**Yes**	**No**
6.	Does the patient cough, wheeze, or have trouble breathing during exercise?	**Yes**	**No**
7.	Does the patient have asthma? **Yes** **No** Does the patient use an inhaler?	**Yes**	**No**
8.	Has the patient ever been treated for high blood pressure or high cholesterol?	**Yes**	**No**
9.	Does the patient have a heart murmur?	**Yes**	**No**
10.	Has a doctor ever denied or restricted participation in sports due to heart or other problem?	**Yes**	**No**
11.	Has the patient had a severe viral infection (e.g.; myocarditis or mononucleosis) within the last year?	**Yes**	**No**
12.	Has the patient ever had a head injury or concussion?	**Yes**	**No**
13.	Has the patient ever been knocked out, become unconscious, or lost their memory?	**Yes**	**No**
14.	Has the patient ever had a seizure?	**Yes**	**No**
15.	Is the patient missing any organs?	**Yes**	**No**
16.	Does the patient use any special protective or corrective equipment or devices (e.g.; knee brace, oral retainer, foot orthotics, neck support)	**Yes**	**No**
17.	Has the patient ever experienced a ligament sprain, muscle strain or swelling in the joints due to injury?	**Yes**	**No**
18.	Has the patient every broken or fractured a bone or dislocated any joints?	**Yes**	**No**
19.	Has the patient had any other problems with pain or swelling in muscles, tendons, bones or joints?	**Yes**	**No**

Please provide explanations to "yes" responses:

HEARING @ 25 dB Date:___Screener Name:_____Signature:_____

(Pure-Tone audiometric Sweep-Check Screen)

HZ	1000	2000	4000
Right	____	____	____
Left	____	____	____

Pass _____ Fail _____

Vision and Hearing: REQUIRED of ALL incoming 1st, 3rd, 5th and 7th grade students AND ALL NEW STUDENTS

VISION Date:_____Screener Name: _____Signature:_____

Right 20/_____ Left 20/_____ Pass _____ Fail _____

SPINAL **Date:_____Screener Name:_____Signature:_____**

L	R	
__	__	High Shoulder
__	__	Shoulder blade stands out more than the other
__	__	Obvious curve of the spine in area rib cage
__	__	Rib hump
__	__	Obvious curve of spine in lower back
__	__	Hip higher than the other side

Other (including round back): _____

Diagnosis: _____

Recommendation:

__ No Treatment

__ Treatment: ___ Observation ____ Brace ____ Surgery

___ Other (describe): _____

___ Referral (describe): _____

Activity Limitation (if any): _____

Additional Comments: _____

Return Appointment and Date, if any: _____

REQUIRED ONLY of ALL incoming 6th – 9th grade students,

Acanthosis Nigricans **Date:_____Screener Name:_____Signature:_____**

AN Marker present (from palpation of Neck)? ___ Yes ___ No

If Yes, please record child's:

DOB:_____ Sex: _____ (M/F) Ethnicity: _____

Height (inches): _____ Weight (lbs): _____ BMI: _____

Blood Pressure (two, 3-5 minutes rest between): _____ _____

___Normal (below 90th %) _____Pre-hypertension (90-95th %) _____Hypertension (95th % or more)

REQUIRED of ALL incoming 1st, 3rd, 5th and 7th grade students AND ALL NEW STUDENTS

Chickenpox (Varicella) Date:_____Name:_____Signature:_____

This is to verify that the above student had the varicella (chickenpox) illness on or about the following date (_____) and does not need the vaccine.

Statement of Clearance

I have examined this student and completed the questionnaire with the patient or legal guardian and have considered their responses in my statement of clearance for participation in physical activities.

I, hereby, certify that this student is:

_____ cleared for all physical activities

_____ cleared, after completing evaluation/rehabilitation for _____

_____ not cleared for _____ Reason: _____

(State specific activity/activities)

This form must be **completed and signed** by a Physician, a licensed Physician Assistant or a Nurse Practitioner. Examination forms signed by any other health care practitioner, including chiropractors, will not be accepted.

Examiner's name _____ Phone Number _____

Address _____

Street City State Zip

Signature _____ Date of Examination _____