

Grade Applied \_\_\_\_\_

Grade Assigned \_\_\_\_\_

Assigned Teacher \_\_\_\_\_

2012-2013 Registration

Shot Record \_\_\_\_\_

### Sunshine Christian School

11601 Montwood Dr. El Paso, TX 79936 915-857-5100 Fax: 915-857-1767

Date of Application: \_\_\_\_\_

Date of Admission: \_\_\_\_\_

Date of Withdrawal: \_\_\_\_\_

## Student Information

Name (Nombre del Niño) (First, M.I. Last) \_\_\_\_\_ Name to be called at school \_\_\_\_\_ Gender \_\_\_\_\_ D.O.B. (Fecha de Nacimiento) \_\_\_\_\_

Address (Dirección) \_\_\_\_\_ Zip Code (Zona Postal) \_\_\_\_\_ Phone # (Telefono) \_\_\_\_\_

Last School Attended \_\_\_\_\_ Teacher Last Year \_\_\_\_\_ Last Grade Completed \_\_\_\_\_

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medications prescribed for long-term continuous use, and any other information which staff should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Siblings attending Sunshine \_\_\_\_\_

## Parent Information

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

e-mail \_\_\_\_\_

e-mail \_\_\_\_\_

## Release Information

I authorize Sunshine School to allow my child to leave the facility ONLY with the following persons, with proper identification:

Name	Phone #	Address	Relationship to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there anyone who is not supposed to be near you child? \_\_\_\_\_

## Authorization for Emergency Medical Attention

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Medical Care Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I give consent for this facility to secure any and all necessary emergency medical care for my child. I understand that any expenses incurred will be borne by the child's family.

\_\_\_\_\_  
Signature—Parent or Legal Guardian

## SUNSHINE CHRISTIAN SCHOOL—CHILDREN'S RISK ASSESMENT

Name of Child \_\_\_\_\_ Date \_\_\_\_\_

## TB Questionnaire

Tuberculosis (TB) is a disease caused by TB germs and is transmitted by an adult with active TB pneumonia. It is spread to another person by coughing or sneezing TB germs into the air. The child may breathe in these germs.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills, and night sweats.

A person can have TB germs in their body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD of Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is available to use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing. As far as you know,

Has your child been around any adult with these symptoms or problems?

Has your child had any of these symptoms or problems?

Has your child been around anyone sick with TB?

(circle one)

Yes No

Yes No

Yes No

Was your child born in or has your child traveled to Mexico or any other country in Latin America, the Caribbean, Africa or Asia for longer than 3 weeks?

Yes No

If so, which country/countries? \_\_\_\_\_

To your knowledge, has your child spent time with anyone who is/has been and Intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?

Yes No

Has your child been recently tested for TB? Yes \_\_\_\_\_ (if yes, specify date \_\_\_ / \_\_\_) No \_\_\_\_\_

Has your child ever had a positive TB skin test? Yes \_\_\_\_\_ (if yes, specify date \_\_\_ / \_\_\_) No \_\_\_\_\_

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) \_\_\_\_\_ and does not need varicella vaccine.

Signature—Parent or Legal Guardian

Date

For additional information regarding immunizations contact the Department of State Health Services at <http://www.tdh.state.tx.us/immunize>

**FOR OFFICE USE ONLY (Vision and Hearing Screening):**

**VISION** R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ \_\_\_ PASS \_\_\_ FAIL

Signature

Date

**HEARING** 1000Hz 2000Hz 3000Hz

R \_\_\_\_\_ \_\_\_ PASS \_\_\_ FAIL

L \_\_\_\_\_

Signature

Date

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In order to better serve your child we would like to gather some information about your child and family. This information will allow us to place your child in the most appropriate classroom setting where he/she will be most productive and successful.

**Important:** This information is confidential, for school use only, this form will be retained in a locked file cabinet.

**Family Information**

Parents Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Remarried \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Single

Are there any other children in the home? \_\_\_\_\_ Yes \_\_\_\_\_ No Names and ages: \_\_\_\_\_

Are there any other adults living in the home? \_\_\_\_\_

What church do you attend? \_\_\_\_\_

Church Attendance:	regular	sometimes	seldom	never
Student	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Have there been any important changes within the family during the last three years? (job changes, moves, births, deaths, illnesses, separations, divorce) \_\_\_\_\_

Are there any members of your child's immediate family (brothers, sisters, parents, grandparents, aunts, uncles) that have a serious health problem? Please list relation of the individual and condition. \_\_\_\_\_

What else would you like us to know about your child or your family? \_\_\_\_\_

**Child's History**

Was your child born early, on time, or late? \_\_\_\_\_ Birth weight \_\_\_\_\_

Were there any complications at the time of birth? \_\_\_\_\_

Since birth, has your child experienced any developmental delays or medical problems? \_\_\_\_\_

Has your child live with you continuously since birth? \_\_\_\_\_

Does anyone assist you with childcare on a regular basis? \_\_\_\_\_

What language do you speak at home? \_\_\_\_\_ What language does your child prefer to speak? \_\_\_\_\_

Does your child speak any language other than the one that he/she speaks at home? \_\_\_\_\_

Describe your child's positive qualities \_\_\_\_\_

Describe your child's challenges \_\_\_\_\_

How would you describe your child's temperament? \_\_\_\_\_

Does your child have any psychological or psychiatric concerns? \_\_\_\_\_

Please complete the following statements: My child (check all that apply)

Obeys the first time that I tell him/her to do something \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

Has been part of a group \_\_\_\_\_ church class \_\_\_\_\_ play groups \_\_\_\_\_ team sports \_\_\_\_\_ club \_\_\_\_\_ other

Hits others \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

Exhibits anxiety when I leave him/her \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

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Sucks his/her thumb \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

Has a difficult time staying focused on the task at hand \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

Has a difficult time sitting still \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

Is shy \_\_\_\_\_ frequently \_\_\_\_\_ sometimes \_\_\_\_\_ rarely \_\_\_\_\_ never

Joins groups of children \_\_\_\_\_ readily \_\_\_\_\_ hesitantly \_\_\_\_\_ needs to be coaxed \_\_\_\_\_ will not

Gets along with others \_\_\_\_\_ well \_\_\_\_\_ fairly well \_\_\_\_\_ poorly \_\_\_\_\_ avoids others

Makes and keeps friends \_\_\_\_\_ many friends \_\_\_\_\_ some friends \_\_\_\_\_ one friend \_\_\_\_\_ none

Likes to \_\_\_\_\_ look at books \_\_\_\_\_ reads books \_\_\_\_\_ play outside \_\_\_\_\_ ride bikes \_\_\_\_\_ sing

Has the following self help skills \_\_\_\_\_ feeds self \_\_\_\_\_ dresses self \_\_\_\_\_ goes to potty by self \_\_\_\_\_ after bowel movement can wipe self  
\_\_\_\_\_ brushes own teeth \_\_\_\_\_ picks up after self \_\_\_\_\_ other \_\_\_\_\_

**Financial Agreement**

I agree to pay \$ \_\_\_\_\_ per month for \_\_\_\_\_ months to cover the tuition cost and building fee at Sunshine Christian School for \_\_\_\_\_ to attend from \_\_\_\_\_ am/pm till \_\_\_\_\_ am/pm \_\_\_\_\_ days per week for the days that are listed as school days on the 2011-2012 school calendar.

I agree:

- To pay the additional fee if my child stays in extended care on a day when school is not in session.
- To pay the additional fee if my child stays in extended care anytime outside of my child's normal class hours.
- To pay the \$20 late fee if my payment is not received by the 15th of the month prior to attendance (\$5.00 each week after).
- That if my payment is not made by the 1st of the attending month, my child will not be able to attend class or extended care.
- If my account goes into default and is not paid, Sunshine Christian School will take legal action and file with the three nation credit reporting agencies (Experian, Equifax, and Trans Union).

\_\_\_\_\_  
Signature of person responsible for account

\_\_\_\_\_  
Print name of person responsible for account

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

**Acknowledgement of Receipt**

\_\_\_\_\_ I have attached the shot records (Initials & Date) \_\_\_\_\_

\_\_\_\_\_ I have attached the signed & dated receipt of Parent Handbook (Initials & Date) \_\_\_\_\_

\_\_\_\_\_ I have attached the signed & dated receipt of Allergy Information Form (Initials & Date) \_\_\_\_\_

**FOR OFFICE USE ONLY**

Other siblings attending SCS ? \_\_\_Y \_\_\_N Records/Transcript Request from another School? \_\_\_Y \_\_\_N

Name (s): \_\_\_\_\_ School: \_\_\_\_\_

Grade (s): \_\_\_\_\_ Date: \_\_\_\_\_

Teacher (s): \_\_\_\_\_ State: \_\_\_\_\_

