APPLICATION FOR ADMISSION

2015-2016 SCHOOL YEAR

Ages 4-8

Student's Name: ____

Last Grade Completed __________ Entering Grade _________ Date of Birth _______________________

Student's Address (City State Zip) ____

Home Phone: ______________________ Primary Language spoken at home ______________________

Racial/Ethnic Group:

( ) American Indian/Alaskan Native ( ) Asian/Pacific Islander ( ) Black, not Hispanic

( ) Hispanic ( ) White, not Hispanic ( ) Multi-racial

OTHER CHILDREN IN FAMILY

Name:_______________________________ Gender___________ Age__________

Name:_______________________________ Gender___________ Age__________

PARENT PERMISSION FOR PUBLICATION OF STUDENT PHOTO: As a parent or guardian of a student at Mission Confluencia,

I give my approval for using photo(s) (no names) of my child for: Yes _____ No_____

Individual and group photos for the yearbook Yes _____ No_____

Individual and/or group photos for the website (no names given) Yes _____ No_____

Development/publicity of the school and its related activities.

(Some examples include, but are not limited to, marketing brochures, annual DVD of school, etc.)

Student Name (print)____________________________________ Grade entering______________

Parent Name (print)___________________________ Parent signature________________________________

Does your child have any Physical Needs/Disabilities of which you are aware? Yes No

If yes, please explain:

____

Does your child have any Learning Needs/Disabilities of which you are aware? Yes No

Do you SUSPECT any disability? Yes No If yes, please explain:

____

____

Has your child been treated by a psychiatrist, psychologist, or counselor? Yes No

Is your child on any type of medication? Yes No If yes, please list all medications whether administered at school or at home: Need/Problem Name of Medication Dosage

____

Is there any additional information you would like to communicate concerning your child?

____

Parent Signature: ____Date:_____________________

EMERGENCY AND HEALTH INFORMATION

2015-2016 SCHOOL YEAR

Student Name __________________________________ Grade _______ Date of Birth_______________________

Address Street City Zip

____

Home Phone: ________________________________Work Phone ___________________________________

(REQUIRED) Alternate Emergency Name ____

Phone __________________________ Cell ____

Alternate Emergency Name ____ Phone

_________________________ Cell ____

Student's Physician ____ Phone _______________________

Hospital Preference: ____

Dentist: ____

Phone________________ Please check if your child has any of the following: ______ Heart Trouble ______

Epilepsy ______ Nosebleeds ______ Asthma _____ Fainting ______ ADD/ADHD ______ Diabetes ______

Hearing or Visual Defects _____ Other Comments

____

____

________ If your child is receiving medication for any reason, please list medication(s) and dosage below. Medication and Dosage:

____

Allergies: (Food, drug, insect, etc.) ____

All medications including over the counter drugs to be given during school hours must be in the original labeled bottle or prescription bottle and be accompanied by the medication permission form signed by the student's physician and parent.

May your child be treated by school personnel for minor injuries? ____ Yes ____ No _______

If an emergency arises, the school will contact the student's mother or father. In the event of an extreme emergency, 911 will be activated, and the student's parents will be notified.

Parent Signature:____ Date:____________________________

APPLICATION QUESTIONS

2015-2016 SCHOOL YEAR

Ages 4-8

What would you like for your child to experience and learn from our community?

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____

How do you see children exploring history and culture to understand themself better?

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How do you see your child honoring and connecting with those around them?

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Why do you want your child to attend Mission Confluencía?

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