Registration Application

Chowchilla Adventist School

22310 Road 13, Chowchilla, CA 93610
(559) 665-1853
www.ChowchillaSchool.org

STUDENT INFORMATION

Legal Name____
First Middle Last

Soc. Sec. #______________________ ☐Male ☐Female

Home Address______________________________________

City_______________________ State______ Zip________

Home Phone_______________________________________

Email Address______________________________________

Date of Birth_______________________________________

Place of Birth______________________________________

Grade applying for__________

Last school attended_________________________________

Does the student attend church? ☐YES ☐NO

If yes, where?______________________________________

Is the student baptized? ☐YES ☐NO

If yes, when?_______________________________________

Lives with: ☐ both parents ☐ mother ☐ father
☐ stepmother ☐ stepfather ☐ other_____________

Are there custody court orders? ☐YES ☐NO

PARENT/GUARDIAN INFORMATION

Mother's Information

Name____
First Middle Last

Occupation____

Work Phone____

Cell Phone____________________ Texting? ☐YES ☐NO

Email Address______________________________________

Denominational Affiliation___________________________

Church membership held at:__________________________

Home address if different from above:________________

____

City________________________ State______ Zip________

Father's Information

Name____
First Middle Last

Occupation____

Work Phone____

Cell Phone____________________ Texting? ☐YES ☐NO

Email Address______________________________________

Denominational Affiliation___________________________

Church membership held at:__________________________

Home address if different from above:________________

____

City________________________ State______ Zip________

FAMILY INFORMATION

Sibling's Name	Age	Grade	School Attending
1.			
2.			
3.			
4.			

ADDITIONAL INFORMATION

Has the student ever been recommended for special education? ☐YES ☐NO
If yes, please explain:

Has the student been previously identified as qualifying for a gifted education program? ☐YES ☐NO
If yes, please explain:

Does the student have an unpaid account at another school? ☐YES ☐NO
If yes, please provide name and address of the school:

Does the student have an unpaid account at Chowchilla Adventist School? ☐YES ☐NO
If yes, when do you expect your balance to be paid-in-full?

Name and address of persons to whom financial statements are to be sent if different from that already given.

Name____ Relationship to student__________________________

Address____

Home phone______________________________________ Cell phone_____________________________________

Student Pledge: I promise to obey all of the school's rules. I promise to cooperate with and be respectful to my teachers and any other adult working or visiting at school. I promise to take care of the school buildings and property. I will live in harmony with the schools' Christian principals.

Date:_____________________ Student's Signature____

Contract of parents/guardian: To the best of our knowledge, the questions on this application are answered completely and truthfully. I am in harmony with the regulations and policies of Chowchilla Adventist School as stated in the school handbook, or as shall be announced by the school board or principal during the school year, and I agree to assume the financial responsibility and pay the cost of tuition for the above student.

Date:_____________________ Parent's Signature____

Admission Checklist

Your child's application will be complete when all of the items listed below are received and approved. Please return items below by mail (22310 Rd 13, Chowchilla, CA 93610), deposit them in the drop box on campus, or arrange a drop off time with the Principal at the school. If you have any questions, please contact the school office at: (559) 665-1853.

Registration Application

Consent to Treatment

Chowchilla Elementary School District- Health Update

Report of Health Examination for School Entry +

Student Medical Record*~

Current Immunization Records

Acknowledgment of Handbook Receipt

School Records from Prior School*

Birth Certificate*

Acceptable Use and Internet Safety Policy

Photo and Video Release

Consent For Pick Up

Tuition Management http://mytads.com/ (Call us for setup code)

Financial Aid Assessment (only if requesting aid)
https://online.factsmgt.com/aid

+ Kindergarten or First graders who did not attend a Kindergarten

* New students only

~ 7th graders only

Version 9-2020

Pacific Union Conference
CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file.

This form must be filled out at the beginning of each school year to cover the activities for the school year. A copy of each student's form must be taken on off-campus activities.

Student's Name

Age Date of Birth mo. day yr. Social Security Number

Address

Parent/Guardian's Name

Father/Guardian
Business Telephone Home Telephone Social Security Number

Mother/Guardian
Business Telephone Home Telephone Social Security Number

Please describe allergies to substances and medication
If on regular medication, please specify Date of last tetanus shot

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician Office Telephone

   Address

2. Family Physician Office Telephone

   Address

Hospital preference Telephone

Please give the names of two relatives or friends who have consented to assume the responsibility of your son or daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name Telephone

   Address

2. Name Telephone

   Address

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or Guardian:_______________________________________ Date: _________________

WHITE – File Copy YELLOW – Off-Campus Activity Copy

CHOWCHILLA ELEMENTARY SCHOOL DISTRICT

Health Update / Información De la Salud

Your child's learning depends on good health. To assist in providing health services at your school, please complete this form.
El aprendizaje de su niño(a) depende de la buena salud. Para asistir en proveer servicios de salud en su escuela, por favor complete este formulario.

Student Information (Información del Estudiante):

Last (Apellido):__________________________First (Primero):__________________________DOB (FDN):____/____/______

Address (Direccion):__________________________City (Cuidad):__________________________

Parent (Padre):__________________________ Phone (Teléfono):__________________________

Doctor Name (Nombre del doctor):__________________________Phone (Teléfono):__________________________

Address (Direccion): __________________________Date of Last Physical (Fecha del ultimo físico)__________________

Dentist Name (Nombre del dentista):__________________________Phone (Teléfono):__________________________

Address (Direccion): __________________________Date of last exam (Fecha del último examen):__________________

Does your child have private insurance? (¿Su niño(a) tiene seguro medico privado?) ☐Yes (Si) ☐No Medi Cal? ☐Yes (Si) ☐ No

DOES YOUR CHILD HAVE / TIENE SU ESTUDIANTE:

☐YES (SI) ☐ NO Allergies? List allergies (Alergias? cuales?) :__________________________

☐YES (SI) ☐ NO Has the allergy required EMERGENCY action (La alergia a requerido acción de EMERGENCIA?)

☐YES (SI) ☐ NO Bee Sting allergy? (Alérgico a piquete de abeja? Describe/Describra):__________________________

☐YES (SI) ☐ NO Does your child need Epipen (Necesita su niño Inyección de Epinefrina)?

☐YES (SI) ☐ NO Asthma? Triggered by: (Asma? Provocada por):__________________________

☐YES (SI) ☐ NO Does your child need an inhaler at school (Necesita inhalador)?

✓ **CHECK THE FOLLOWING HEALTH CONCERNS THAT PERTAIN TO STUDENT:** (explain / explique)
Marque las siguientes referencias de concierne de salud que pertenecen al estudiante:

	Wears Glasses	(Antejos)		Hearing Aid (L/R)	(Audífono L/R)
	Lazy Eye (L/R)	(Ojo Flojo L/R)		Frequent Ear Infections	(Infecciones Frecuente de Oídos)
	Frequent nose bleeds	(Frecuente Hemorragia Nasal)		Hearing Difficulty	(Dificultad con Oír)
	Breathing problems	(Problemas de la Respiración)		Began Menstration	(Empezó menstruación)
	Skin problems	(Problemas de la Piel)		Diabetes	(Diabetes)
	Blood disorder	(Trastorna de Sangre)		Epilepsy/seizures	(Epilepsia/Ataques)
	Dental problems	(Problemas Dentales)		Heart Condition	(Condición del Corazón)
	ADD/ADHD	(ADD/ADHD)		Bone/Joint problems	(Problemas de hueso o coyuntura)
	Anxiety/Panic Attacks	(Miedo/Ansiedad)		Neurological/Tourettes	(Neurológico)
	Autism	(Autismo)		Headaches	(Dolores de Cabeza)
	Stomach Problems	(Problemas del estomago)		Other	(Otro)
	Bladder/Bowel problems	(Problemas de la Vejiga)		Other	(Otro)

If any health concerns were checked, please explain (Si otras referencias de concierne de salud fueron marcados, favor de explicar):

____

____

MEDICATION (MEDICAMENTO):

(☐ At home only (En casa solamente) ☐ Needs at school (Necesita en la escuela) ☐ For Emergency only (Para emergencia solamente)

List Medications and reasons prescribed (Nombre los medicamentos que usan y la razón por el uso):__________________________

____

OTHER (OTRO)

Serious Illness or injuries (Liste enfermedades o heridas serias):__________________________

Surgeries (Intervención quirurgicas):__________________________

Special Education health care needs (Asistencia medica de Educación Especial): (explain/explique):__________________________

IF YOUR STUDENT REQUIRES MEDICATION AT SHOOL OR A PHYSICAL EDUCAITON EXCUSE, PLEASE GET THE NECESSARY FORMS FROM SCHOOL FOR YOUR DOCTOR TO FILL OUT.
Si su estudiante requiere medicamento en la escuela o una exención de educación física, favor de obtener las formas necesarias departe de la escuela para que el doctor las complete.

Parent Signature (Firma de Padres):__________________________Date (Fecha):__________________

State of California—Health and Human Services Agency
Primary Care and Family Health Division

Department of Health Services
Children's Medical Services Branch
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTHDATE—Month/Day/Year

ADDRESS—Number/Street	City	ZIP Code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE
Health History	
Physical Examination	
Dental Assessment	
Nutritional Assessment	
Developmental Assessment	
Vision Screening	
Audiometric (hearing) Screening	
Tuberculin Test (Mantoux/PPD)	
Blood Test (for anemia)	
Urine Test	
Blood Lead Test	
Other	

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DTaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) **(Required for child care/preschool only)**					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER (optional) *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

❒ Examination shows no condition of concern to school program activities.

❒ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: (please explain)

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

❒ Please check this box if you ***do not*** want the health examiner to fill out Part III.

➤ ______________________________ ____________
Signature of parent or guardian Date

Name, address, and telephone number of health examiner

➤ ______________________________ ____________
Signature of health examiner Date

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

STUDENT MEDICAL RECORD

Name ________________ Birth Date ________ SSN ________________
Address ________________________________
Name of Father ________________ Name of Mother ________________
School ________________ Grade ________________

HISTORY Past illnesses and allergies. Please check those he/she has had.

Cancer	_______	Measles	_______	Ear Infections	_______
Chicken Pox	_______	Rheumatic Fever	_______	Allergies, asthma	_______
Diabetes	_______	Scarlet Fever	_______	hay fever	_______
Diptheria	_______	Tuberculosis	_______	insect bites	_______
Epilepsy	_______	Whooping Cough	_______	penicillin	_______
Heart disease	_______	Other	_______	other drugs	_______

Explain briefly factors such as surgeries, serious accidents or injuries, congenital defects, speech defects, vision problems, which may affect the child's school experience. ________________________________
____
____

* Please attach current immunization card with this form before submitting to the school.

PHYSICIAN'S EXAMINATION

Height ____________ Weight ________________ Blood Pressure ________________

AREA	NORMAL	ABNORMAL	NOT EXAMINED	Explain Abnormalities
Skin				
Eyes, Vision, Glasses				
Ears, Hearing				
Nose, Throat				
Mouth, Teeth, Speech				
Glands				
Chest, Lungs				
Cardiovascular, Heart				
Abdomen				
- Enlargement				
- Tenderness				
- Hernia				
Spine, Back				
Scoliosis for Grade 7				
Posture				
Extremities				
Genitourinary				
Nervous System Reflexes				

Nutritional status and general appearance of the child ________________________________
____

Recommendations for additional medical or dental care ________________________________
____

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling. Yes _________ No __________

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted ________________________________

Date __________ Signed ________________________________
(Physician)
Address ________________________________

* To be completed by the family physician and kept on file at the school for all children, a) entering school for the first time, b) at grade seven (this should include the scoliosis examination, c) at least once in grade nine through twelve, d) at other grades, when required by the Conference Board of Education.

Chowchilla Adventist School
ACKNOWLEDGMENT of HANDBOOK RECEIPT

I acknowledge that I have received a copy of the current school handbook. I also understand that my student(s) and I are responsible for reviewing the handbook and complying with all of its provisions. I will speak to the Principal and/or my student's teacher if I have any questions, concerns, or need clarification.

Parent/Guardian #1 Name: ______________________________

Parent/Guardian #1 Signature: ______________________________ Date:__________

Parent/Guardian #2 Name: ______________________________

Parent/Guardian #2 Signature: ______________________________ Date:__________

Child #1 Name: ______________________________

Child #1 Signature: ______________________________ Date:__________

Child #2 Name: ______________________________

Child #2 Signature: ______________________________ Date:__________

Child #3 Name: ______________________________

Child #3 Signature: ______________________________ Date:__________

Chowchilla Adventist School

Acceptable Use and Internet Safety Policy

Student Name: ______________________

To access Chowchilla Adventist School's internet, I agree to follow the following rules:

1. I will only be on the computer/internet when given permission by a school teacher.
2. I will not access the schools wireless internet through my cell phone, I-pod, I-pad, kindle or any other electronic device without a teacher's permission.
3. When given permission to access the internet I will use it for educational purposes only.
4. I will not install any software.
5. I will not access You Tube, Facebook or similar web sites.
6. I will not access gaming sites.
7. I will tell the teachers or supervisor right away if I come across any information or pictures that go against school rules/guidelines.
8. I will not access or participate in any chat systems.
9. I will not threaten anyone online or use any improper language.
10. If I get a message with threats or improper language, I will tell the teachers and/or my parents right away.
11. I will follow school rules about how long I can be online, when I can be online and the sites I can visit.

I have read, understand and agree to abide by the terms of the Acceptable Use and Internet Safety Policy. Should I commit any violation or in any way misuse my access to Chowchilla Adventist School's computer network and the internet, I understand and agree that my access privilege may be revoked, and school disciplinary action may be taken against me.

(Sign Internet agreement on next page)

Chowchilla Adventist School

I _____________________ agree to follow the Acceptable Use and Internet Safety Policy.

________________________ ___________ _______________

Student Signature Grade Date

As the parent or legal guardian of the above student, I have read, understand and agree that my child will comply with terms of our school's Acceptable Use and Internet Safety Policy. I understand that it is impossible for the school to restrict access to all offensive and controversial materials and understand my child's responsibility for abiding by the policy.
(More on next page)

I hereby give permission for my child to use the computer network and the Internet.

____

Parent or Guardian Name(s)

____

Parent or Guardian Signature(s)

Chowchilla Adventist School

Photo and Video Release

2020-2021 School Year
Permission to Use Student's Photograph

During the course of the academic year, Chowchilla Adventist School may wish to use photographs of our students on our school newsletters, brochure, in educational publications, or on our school website or social medial accounts. Any such photographs would highlight the students either demonstrating learning techniques or participating in approved school activities.

Student's Name:____

_____I/We consent to the use of my child's image in Chowchilla Adventist School publications.

_____I/We consent to the use of my child's image in Chowchilla Adventist School publications, however we would want to be notified before the picture is published in the school newsletter or school website.

_____I/We DO NOT consent to the use of my child's image in any Chowchilla Adventist School publications, with the exception of our new school year book.

Parent's/guardian's signature: ___________________________________

Date: __________________

Chowchilla Adventist School
CONSENT FOR PICK UP

This form is designated to authorize specific person who may regularly pick up your child(ren) from the premises of Chowchilla Adventist School.

School Year:________________

Name(s) of your child(ren):

________________________________ Grade: __________

________________________________ Grade: __________

________________________________ Grade: __________

Person(s) who may pick up my child(ren) (Must be at least 18 years old):

Name: ________________________________ Relationship: ________________

Phone Number:____________________

Name: ________________________________ Relationship: ________________

Phone Number:____________________

Name: ________________________________ Relationship: ________________

Phone Number:____________________

Name: ________________________________ Relationship: ________________

Phone Number:____________________

If you have an emergency and need someone not on this form to pick-up your child, please contact the school to provide your consent.

Is there anyone who is NOT authorized to take your child from school? Yes ___ No ___
If yes, please list and provide pictures to the Principal.

____ ________________
Parent/Guardian Signature Date

Version 2-2019