

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) <http://mytads.com/>

+ Kindergarten or First graders who did not attend a Kindergarten

* New students only

~ 7th graders only

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 (Ciudad): _____
 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/Describe): _____
 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) (Audifono 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 Menstruation (Empezó menstruación)
Skin problems (Problemas de la Piel)	Diabetes (Diabetes)
Blood disorder (Trastoma 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): _____

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 _____
Diphtheria _____	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

2019-2020 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