

DELAWARE CHRISTIAN SCHOOL

Pre-K Application For Admission

APPLICATION FEE \$50 per student (*non-refundable*)

Date _____

Student's Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____

Child's Birth Date _____

Father's Name _____ Occupation _____

Phone (home) _____ (work) _____ (cell) _____ (email) _____

Mother's name _____ Occupation _____

Phone (home) _____ (work) _____ (cell) _____ (email) _____

Does child have any physical or developmental disabilities? Yes _____ No _____

If yes, please explain _____

Church family is attending _____

By signing below you are indicating that you are in agreement with the mission, philosophy and vision of Delaware Christian School with regard to your child's education.

***Admission to Delaware Christian School K-12 grades requires that one parent be a born-again believer and interview with a DCS administrator.**

Father _____ Mother _____

Please return completed form with non-refundable application fee to:
Delaware Christian School, 45 Belle Avenue, Delaware, Ohio 43015

For Office Use Only

DELAWARE CHRISTIAN SCHOOL PRESCHOOL PHYSICIAN REPORT

Ohio Law requires a current physical examination each year for preschool students and completed immunization records to be on file in the school office **before the first day of attendance.**

Name _____ M ___ F ___ Birthdate: ___/___/_____

PARENTS: Please complete

Physician's name: _____ Phone: _____

Today's Date: ___/___/_____

Past Medical History:

Has your child been seriously ill? _____ Explain _____

Has your child had an operation? _____ Explain _____

Has your child any serious accident? _____ Explain: _____

List the following medications, food supplements, modified diets or fluoride supplements currently being administered to your child:

ANY medication and dosage: _____

ANY food supplements? _____

ANY fluoride supplements? _____

Any modified diet? _____

Parent Name (please print)

Parent Signature

PHYSICIANS: Please complete

Please circle any present health concern:

Bee sting allergy / allergies / asthma / diabetes / congenital anomalies / emotional problems / urinary difficulties / hearing difficulties / visual difficulties / abnormal bleeding / scoliosis / seizures / cardiac difficulties

Explain: _____

Other: _____

ANY medication and dosage (list) _____

Has the child been hospitalized? _____ Explain _____

OVER

IMMUNIZATIONS:

NUMBER OF DOSES REQUIRED FOR CHILDREN 20 MONTHS OF AGE AND OLDER:
 DTP - 4 doses of any combination of DTP, DT Td vaccine. If the third dose was given at age 6 or older, no further doses are required.

HIB – minimum of 1 dose required.

POLIO - 3 doses are required.

MMR – 1 dose is required which must be administered on or after the child’s first birthday.

HEPATITIS B – 3 doses are required.

VARICELLA (CHICKEN POX) – 1 dose required before kindergarten.

***Dose of vaccine must be denoted by complete month/date/year**

	FIRST	SECOND	THIRD	FOURTH	FIFTH
DTP (4 Required)					
HIB					
POLIO (3 Required)					
MMR (1 Required)					
HEPATITIS B (3 Required)					
VARICELLA					
TUBERCULIN TEST *If foreign born or traveled to high risk country			RESULT: ___negative ___positive		

This is to state that _____
Child's Name

- is free from communicable disease (including TB if student is foreign-born or has traveled to a high risk country in the last 12 months. If this applies to the child, result of skin test is _____; result of chest x-ray if skin test is positive _____)
- has received immunizations required by statute for admission to school under Section 3.313.671 of the Ohio Revised Code
- _____ is entirely within normal limits

Date of Examination: _____ Physician’s Signature: _____

Physician’s Address: _____

Physician’s Phone Number: _____ - _____ - _____

Dentist’s Name: _____

Dentist’s Address: _____

Dentist’s Phone Number: _____ - _____ - _____

DELAWARE CHRISTIAN SCHOOL MEDICATION AUTHORIZATION FORM

Child's Name: _____ Date of Birth ____/____/____

Today's Date ____/____/____

To administer a prescription medication:

- The medication must be in its original container, with a legible label from the pharmacy indicating the child's name, date, name of medicine, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's/nurse practitioner's name, pharmacy name and telephone number
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label (twins and siblings can not share)
- A separate authorization is required for *each medication* and *each episode* of illness
- Label constitutes the physician's/nurse practitioner's order
- Parent/Guardian is to give as many doses as possible at home.

Medication: _____

Reason for medication: _____

Start date ____/____/____ End date ____/____/____

Dosage: _____ Times to be given: _____ AM _____ PM

Last dosage was given at _____ AM/PM On date ____/____/____

Route: by mouth, skin (location) _____, eye (R/L)

Possible side effects: _____

Special handling/storage instructions: _____ Refrigeration Y/N

Parent/Guardian Signature (required): _____

Non-Prescription Medication:

- Parent is required to bring these medications from home.
- Medication must be in an original container, with child's name on the container.

Medication: _____

Reason for medication _____

Start date ____/____/____ End date ____/____/____

Dosage: _____ Times to be given at child care: _____ AM _____ PM

Last dosage was given at _____ AM/PM On date ____/____/____

Route: by mouth, skin (location) _____, eye (R/L)

Possible side effects: _____

Special handling/storage instructions: _____ Refrigeration Y/N

Parent/Guardian Signature (required) _____

Unused medication: Returned to Parent Yes/No or, discarded appropriately (circle one)

By: _____ Date ____/____/____

Delaware Christian School CHILD RELEASE PERMISSION FORM

Delaware Christian School Preschool has my permission to release my child,
_____ to the following people:

NAME	RELATIONSHIP TO CHILD	PHONE #

I understand that I *must notify Delaware Christian School* on days when someone other than a parent will pick up my child from school. This includes parents of other students in the school. In the event that I cannot notify my child's teacher, the staff is authorized to release my child to the above adults ONLY.

Parent/Guardian's name (please print)

Parent/Guardian's signature/date

DELAWARE CHRISTIAN SCHOOL

Photo/Video/Media Release Form

Dear Parent/Guardian:

During the school year, our school will hold events that the news media and the district may like to feature. A representative may be at school to gather photographs and/or video footage highlighting the event and featuring the faces of Delaware Christian School. We value your child's participation, and ask for your permission to include him or her. Please indicate by checking the box(es) below whether your child has your permission to participate.

You may update this form at any time by contacting our main office at 740-363-8425.

Check All That Apply:

- I give my permission to have my child interviewed and photographed/videotaped by the news media.
- I give my permission to have my child photographed by the school. Photos may be used on the school website.
- I give my permission to have the school feature my child's school work (e.g. art, essays, etc.).
- You may provide a credit to my child if his/her work is shown.
- First Name Only
- First & Last Name
- I give my permission to have my child videotaped by the school. Videos may be viewed by staff or the public.
- Please **do not** include my child in these activities. I **do not** want my child photographed or videotaped.

Comments:

Child's name (please print)

Parent/Guardian's name (please print)

Parent/Guardian's signature/date

DELAWARE CHRISTIAN SCHOOL EMERGENCY CONTACTS

2011-2012

Child's name: _____
Medical condition: _____
Current medications: _____

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Medical condition: _____
Current medications: _____

USE BACK OF SHEET FOR ADDITIONAL CHILDREN

Family doctor: _____
Doctor's phone: _____
Family dentist: _____
Dentist phone: _____

Parent's/guardian's name: _____
Home phone: _____
Work phone: _____
Cell phone: _____

Alternate contact's name: _____
Home phone: _____
Work phone: _____
Cell phone: _____

Alternate contact's name: _____
Home phone: _____
Work phone: _____
Cell phone: _____

Notes:

In case of illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the alternate contact number above. I understand this person will transport and provide care for my child. In case of emergency, the school staff will contact 911. Every attempt will be made to contact a parent or a designated emergency contact. I understand that Grady Memorial Hospital will be the primary source of emergency care.

Parent's signature

Print parent name

Date

A new Emergency Contacts sheet must be submitted yearly and every time information changes.