

BETHEL BAPTIST SCHOOL

Application for Enrollment – International Student

Please print clearly using black or blue ink.

Today's Date ____/____/20____

Circle the grade for which student is applying:											
1	2	3	4	5	6	7	8	9	10	11	12

Student Information

Name **exactly** as it appears on passport _____ English Name (if any) _____ SEVIS ID# (if any) _____

Country of Birth _____ City of Birth _____ Country of Citizenship _____ Date of Birth (mm/dd/yyyy) ____/____/____ Age ____ Gender (M/F) ____

Complete Address in Home Country _____

Province or County in Home Country _____ City _____ Country _____

U.S. Address (if any): Number & Street _____ City _____ Zip Code _____

School Last Attended _____ GPA _____ List Allergies and/or Prescription Medications Taken by Student _____

How many years will your child study at Bethel Baptist School? _____

Has your child ever been promoted more than one grade in a year? ___Yes ___No If yes, when? _____

Has the student ever repeated a grade? ___Yes ___No If yes, what grade? _____

Has the student recently had any serious illness? ___Yes ___No If yes, what illness? _____

Family Information

Father's Last Name _____ Father's First Names _____ Email Address (required) _____

Father's Employer _____ Work Phone Number (____)____-____ Cell or Home Phone (please circle one) (____)____-____

Mother's Last Name _____ Mother's First Names _____ Email Address (required) _____

Mother's Employer _____ Work Phone Number (____)____-____ Cell or Home Phone (please circle one) (____)____-____

Names and ages of brothers and sisters:

Name _____	Age ____	Name _____	Age ____	Name _____	Age ____
------------	----------	------------	----------	------------	----------

What church or religious group does the student attend (if any)? _____

Do you understand that Bethel Baptist School is a Christian School and agree that your child will attend religion classes and learn the Bible, its history, and the teachings of Jesus Christ? ___Yes ___No

Do you agree to authorize this school to use discipline that it considers wise and necessary for the welfare of your child? ___Yes ___No

Are you applying, or do you intend to apply for a Permanent Residence Card (Green Card)? ___Yes ___No

Father's Signature _____ Date _____

Mother's Signature _____ Date _____

Medical History (Fill in the circles [●] for all that apply.)

It is *mandatory* that pupils who show symptoms of a communicable disease or illness be excluded from classes until cleared by a doctor and approved by school administration.

Father's Health: Excellent Average Poor

If poor, please explain: _____

Mother's Health: Excellent Average Poor

If poor, please explain: _____

If either parent(s) are deceased, state cause: _____

Past Diseases (Please mark any of the following diseases that your child has had.)

- Chicken Pox Mumps Rheumatic Fever
- Diphtheria Pneumonia Scarlet Fever
- Measles Polio Whooping Cough

Other (explain): _____

Recent Illness or Disability (Please mark any of the following that your child has experienced.)

- | | | |
|---|--|--|
| Abdominal Pains <input type="radio"/> | Dizziness <input type="radio"/> | Persistent Cough <input type="radio"/> |
| Allergies <input type="radio"/> | Fainting Spells <input type="radio"/> | Pink Eye <input type="radio"/> |
| Asthma <input type="radio"/> | Growing Pains <input type="radio"/> | Poor Vision <input type="radio"/> |
| Breath Shortness <input type="radio"/> | Hay Fever <input type="radio"/> | Ringworm <input type="radio"/> |
| Colds (Four or More Yearly) <input type="radio"/> | Hearing Difficulty <input type="radio"/> | Sore Throat (Frequent) <input type="radio"/> |
| Convulsions <input type="radio"/> | Heart Disease <input type="radio"/> | Speech Difficulty <input type="radio"/> |
| Crippling Conditions <input type="radio"/> | Hernia (Rupture) <input type="radio"/> | Sties (Frequent) <input type="radio"/> |
| Dental Defects <input type="radio"/> | Impetigo <input type="radio"/> | Tires Easily <input type="radio"/> |
| Diabetes <input type="radio"/> | Leg Pains (Frequent) <input type="radio"/> | Urination (Frequent) <input type="radio"/> |
| Discharging Ears <input type="radio"/> | Nosebleed <input type="radio"/> | |

Other (explain): _____

Immunization (Please mark any of the following for which your child has been immunized.)

- | | | | |
|-----------------------------------|-----------------------------------|---------------------------------------|--------------------------------------|
| Chicken Pox <input type="radio"/> | Hepatitis B <input type="radio"/> | Schick Negative <input type="radio"/> | Tetanus <input type="radio"/> |
| COVID-19 <input type="radio"/> | Measles <input type="radio"/> | Smallpox - Scar <input type="radio"/> | Typhoid <input type="radio"/> |
| Diphtheria <input type="radio"/> | Polio <input type="radio"/> | Tdap Booster <input type="radio"/> | Whooping Cough <input type="radio"/> |

Other (explain): _____

Personal Record (Please mark any of the following that pertain to your child.)

- | | | | |
|---|--|-------------------------------------|------------------------------|
| Angers easily <input type="radio"/> | Excessive Fears <input type="radio"/> | Overly Active <input type="radio"/> | Other (Please explain below) |
| Bites Fingernails <input type="radio"/> | Gets along with Others <input type="radio"/> | Shy <input type="radio"/> | _____ |
| Eats Breakfast <input type="radio"/> | Likes School <input type="radio"/> | | _____ |

What is the student's regular bedtime? ____:____ p.m. rising time? ____:____ a.m.

Does your child have any disability due to disease or accident? Yes No

Explain: _____

Has your child had a skin test for tuberculosis? ___Yes ___No When? _____

Has he been associated with a tubercular patient? ___Yes ___No When? _____