

BETHEL BAPTIST SCHOOL

Application for Enrollment

Please print using black ink.

Date ____/____/20____

Student Information

Last Name First Name Middle Name Social Security Number

Street Address City Zip Code Date of Birth (mm/dd/yyyy)

Grade Entering Age Last School Attended Grade Average Gender (M/F) (____) -
Student's Telephone Number

List Allergies and/or Prescription Medications Taking Place of Birth

Has your child ever been retained in a grade? Yes No If yes, what grade? _____

Has your child had any serious illness recently? Yes No If yes, what illness? _____

Has your child ever been promoted more than one grade in a year? Yes No If yes, when? _____

Family Information

Father's Last Name Father's First Name (____) -
Home or Cell Phone (circle one)

Father's Employer (____) -
Work Phone Number Email Address

Mother's Last Name Mother's First Name (____) -
Home or Cell Phone (circle one)

Mother's Employer (____) -
Work Phone Number Email Address

Names and ages of brothers and sisters:

Name Age Name Age Name Age

Church Currently Attending

Do you agree to authorize this school to use such discipline as
it considers wise and necessary for the welfare of your child? 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"/> | Nose Bleed <input type="radio"/> | |

Other (explain): _____

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

- | | | | |
|-----------------------------------|---------------------------------------|---------------------------------------|--------------------------------------|
| Chicken Pox <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"/> |
| Hepatitis B <input type="radio"/> | Schick Negative <input type="radio"/> | Tetanus <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? _____

REMINDER: No pupil will be excused from P.E. without a written notice from a physician.