



KINGDOM ACADEMY PROGRAM

BATES COMMUNITY
DEVELOPMENT CORPORATION
STUDENT ENROLLMENT FORM

Page | 1

Please read and fill in all sections completely. An enrollment form must be completed for each child who is enrolled in the program.

Today's Date: _____

Application for (check one): After School Summer

SECTION I STUDENT INFORMATION

Child's Name: _____ Preferred Name or Nickname: _____

Child's Gender: Male Female Date of Birth: ____/____/____

Your Relationship to Child: Parent Guardian

Does the child live with you? Yes No

If no, please provide name/address/telephone number of the head of household where the child currently lives.

Name: _____

Address: _____

Telephone: _____

2017-2018 Grade Level _____ Name of School _____

Type of school enrolled:

- Public
- Charter School
- Faith-based
- Private

Has this child ever repeated a grade?

- Yes
- No

Do we have your permission to access the child's student records?

- Yes
- No

Does this child currently participate in the Free/Reduced Lunch program? Yes No

Will this child be walking or riding the bus to or from the site each day to attend the program?

- Yes No

Will this child regularly depart early from the program to attend another activity?

- Yes No

If yes, please describe arrangements:

Is this child limited or prevented in any way in his/her ability to do the things most children of the same age can do?

- Yes No

If yes, please explain:



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Page | 2

Today's Date: _____

Child's Name _____

SECTION II PARENT/GUARDIAN INFORMATION

Your Name: _____

Number and Street Address: _____

City: _____ State: _____ Zip Code: _____

How many people live in your household? # of Adults _____ # of Children _____ # of Seniors _____

Do you currently live or have lived in public housing in the last 2 years? Yes No
If yes, please list the name of the public housing where you live/lived: _____

Race/Ethnicity

- | | |
|---|--|
| <input type="checkbox"/> African American/Black, non Latino | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> White, Non-Latino |
| <input type="checkbox"/> Asian, Native Hawaiian or Pacific Islander | <input type="checkbox"/> Other |

Your Occupation: _____ Highest Grade Completed or Degree Earned: _____

Home Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

Cell Phone: (____) ____ - _____ Email: _____

Emergency Contact (If parent/guardian cannot be reached):

Name: _____ Relationship to Child: _____

Home Phone: (____) ____ - _____ Work Phone: (____) ____ - _____

Cell Phone: (____) ____ - _____ Email: _____

Please list at least three other adults authorized to pick up this child:

<u>Name</u>	<u>Relationship to Child</u>	<u>Phone Number</u>
-------------	------------------------------	---------------------

1.

2.

3.

4.

5.

Today's Date: _____

Child's Name _____

SECTION III
HEALTH HISTORY

Has a doctor or health professional ever told you that this child has any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Depression or anxiety problems |
| <input type="checkbox"/> Bone, joint, or muscle problems | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Hay fever or any kind of respiratory allergy | <input type="checkbox"/> Any kind of food or digestive allergy |
| <input type="checkbox"/> Eczema or any kind of skin allergy | <input type="checkbox"/> Three or more ear infections |
| <input type="checkbox"/> Frequent or severe headaches, including migraines | |
| <input type="checkbox"/> Autism | |
| <input type="checkbox"/> Attention Deficit Disorder or Attention Deficit Hyperactive Disorder, that is ADD or ADHD | |
| <input type="checkbox"/> Behavior or conduct problems | |
| <input type="checkbox"/> Stuttering, stammering, or other speech problems | |
| <input type="checkbox"/> Diabetes If yes, is child able to take medication without assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Other, | |
| If yes, please describe: _____ | |
| <input type="checkbox"/> None | |

Please list any allergies not mentioned above:

Does this child currently need or use medicine prescribed by a doctor?*

- Yes No

If yes, please list the medication(s):

**Please note that Kingdom Academy staff and volunteers cannot legally be responsible for administering medication to your child.*

Please provide the following information:

Does this child have health insurance? Yes No

If yes, complete the information below. *(Please include a copy of the child's insurance card with this enrollment form)*

Health Insurance Carrier: _____ Name of Policy Holder: _____

Identification Number: _____ Group Number: _____

Please explain any special procedures that should be followed in the event of a medical emergency:

Today's Date: _____

Child's Name _____

SECTION III (cont.)
HEALTH HISTORY

Has a doctor, health professional, teacher, or school official ever told you that this child has learning challenges?

Yes No

If yes, please describe

Please indicate below if this child receives ECE (Exceptional Child Education) Services for any of the following:

Developmental delay

If yes, please describe: _____

Emotional/mental disability

Learning delay/disability

Physical impairment

If yes, please describe: _____

Speech/language impairment

Other, please describe

SECTION IV
OTHER INFORMATION

What other enrichment or extra-curricular activities does this child participate
(for example, organized sports, music or dance lessons, academic tutoring, clubs or organizations)?

How did you hear about this program?

SECTION V
PARENT/GUARDIAN CERTIFICATION

I hereby certify that the statements in this application are correct and true. I understand that the child's enrollment in *Kingdom Academy* is based, in part, on the information provided within this application and my agreeing to the terms as outlined in writing by the *Kingdom Academy* program.

Print Name _____

Signature _____ Date _____