

STUDENT APPLICATION FOR ADMISSION—GRADES K-5

Please type or print. All information must be provided for applicant to be considered.

Father's (Guardian) name

Mother's (Guardian) name

Student's full legal name

Date of birth

Social Security #

1. In which activities is your child involved? _____

2. Has your child repeated a grade? No___ Yes___

3. List all previous schools attended.

Name of School

Complete Address

Grade

Years

4. What is your child's attitude toward school and teachers? _____

5. What is your child's attitude toward discipline? _____

6. Student History

Does your student have a ___physical or emotional condition ___learning disability ___ADHD
if yes, please explain. _____

Has your student ever had an Individualized Education Plan (IEP)? ___Yes ___No

If yes, in which areas has your child been evaluated?

___Educational ___Psychological ___Physical ___Occupational

If tested, please explain. _____

Does your child wear glasses or corrective lenses? ___No ___Yes

Does your child wear a hearing aid? ___No ___Yes

Is there any significant history in the pregnancy or delivery of your child? (Information can alert us to developmental factors.) No Yes

If yes, please explain. _____

Is any language other than English used in the home? No Yes

If yes, what language? _____

Has your child ever been enrolled in a special class or received tutoring? No Yes

Has the family/child been recommended for or participated in any counseling? Please explain. _____

Has your child ever been suspended____, expelled____, or asked to withdraw____ from any school? If so, please explain in detail (from what school and why). _____

10. Check any of the following characteristics about your child that you have observed at home.

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Thoughtful | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Jealous |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Even-tempered | <input type="checkbox"/> Alert |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Destructive | <input type="checkbox"/> Courageous |
| <input type="checkbox"/> Sulks | <input type="checkbox"/> Stammers/stutters | <input type="checkbox"/> Aloof |
| <input type="checkbox"/> Listless | <input type="checkbox"/> Daydreams | <input type="checkbox"/> Cheerful |
| <input type="checkbox"/> Orderly | <input type="checkbox"/> High-strung | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Restless | <input type="checkbox"/> Calm |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Sharing |
| <input type="checkbox"/> Breath holding | <input type="checkbox"/> Affectionate | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Follower | <input type="checkbox"/> Talkative | <input type="checkbox"/> Assertive |
| <input type="checkbox"/> Helpful | <input type="checkbox"/> Honest | <input type="checkbox"/> Compulsive |

11. Does your child need extended care (until 5:30 PM) at an additional fee of \$3.00/hour per student?
 No Yes

If yes, please indicate below *specific* days and *pick-up* times.

Monday_____	Tuesday_____	Wednesday_____	Thursday_____	Friday_____
Time_____	Time_____	Time_____	Time_____	Time_____

EMERGENCY MEDICAL FORM

PIONEER VALLEY CHRISTIAN SCHOOL, SPRINGFIELD, MASSACHUSETTS

Please complete the following information and return it to the school with your application material.

Full Name _____

Address _____

Telephone _____ Date of Birth ____/____/____ Grade _____

Mother _____ Business Telephone _____

Cellular Telephone _____

Father _____ Business Telephone _____

Cellular Telephone _____

Guardian _____ Business Telephone _____

Cellular Telephone _____

Student resides with (please check only one): Mother Father Both Other

If parent or guardian cannot be reached in an emergency, list names of individuals we may call to pick up your child.

Name _____ Daytime Telephone _____

Cellular Telephone _____

Name _____ Daytime Telephone _____

Cellular Telephone _____

Name _____ Daytime Telephone _____

Cellular Telephone _____

Student's Physician _____ Telephone _____

State hospital preference _____

Has student been seen by his/her physician in the last two years? No Yes Date _____

I hereby authorize you to call my child's pediatrician if I cannot be reached and such a call is deemed necessary. Additionally, I give permission to school personnel to treat and/or transport in the event of an emergency.

Is your child covered by health insurance? Yes No

Please submit a copy of your child's insurance card with this form.

Student's health insurance carrier _____ Policy # _____

Signature of Parent/Guardian _____ Date _____

I give permission to the school nurse and/or designated school personnel to administer the following:

- Acetaminophen (Tylenol) Antacids Benadryl Ibuprofen (Advil)
 Antibiotic Ointment Hydrocortisone Cream All of the above None of the above

Name of medicines taken on a regular basis and for what purpose _____

Student is allergic to: _____

Signature of Parent/Guardian _____ Date _____

ANNUAL STUDENT HEALTH SERVICES REPORT

Does student have any chronic health conditions, please list. _____

Does student have difficulty concentrating? Yes No

If yes, please explain _____

Restrictions: Classroom _____ Physical Education _____

Student is allergic to _____

Are allergy injections being administered? Yes No

Does the student have an Epipen prescription? Yes No

Vision: Known problem: _____

Glasses Contact Lenses

Preferential seating needed? Yes No

Hearing: Known problem: _____

Frequent ear infections Tubes

Preferential seating needed? Yes No

Scoliosis Screening: Known problem: _____

Permission to screen: Yes No

Any illnesses, injuries, or surgery? _____

Any additional information of which the school should be aware: _____

I give permission to the school to share this information with the appropriate school personnel.

Signature of Parent/Guardian _____ Date _____

Please be aware if your child plans on playing a school sport, they must have a current physical sports exam on file at the school. The form must be signed and dated within thirteen months of the particular athletic season.

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth _____

Medical History

Pertinent Family History

Current Health Issues

Y N

- Allergies – Please list. Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen® Yes No
- Asthma – Asthma Action Plan Yes No (If yes, please attach.)
- Diabetes Type I Type II
- Seizure disorder _____
- Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) – Please circle those administered in school; a separate medication order form is needed for each medication administered in school. _____

Physical Examination

Date of Examination _____

Height _____ (____%) Weight _____ (____%) BMI _____ (____%) BP _____

(Check if normal; if abnormal, please describe.)

- | | | |
|--|--|--|
| <input type="checkbox"/> General _____ | <input type="checkbox"/> Lungs _____ | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Neurologic _____ |
| <input type="checkbox"/> HEENT _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental/Oral _____ | <input type="checkbox"/> Genitalia _____ | |

Screening

- | | | |
|---|--|--|
| Vision: Right Eye <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Hearing: Right Ear <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Postural Screening <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) |
| Left Eye <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | Left Ear <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | (Scoliosis/Kyphosis/Lordosis) |
| Stereopsis <input type="checkbox"/> (Pass) <input type="checkbox"/> (Fail) | | |

Laboratory Results Lead _____ Date _____ Other _____

Examination Normal

Targeted TB Skin Testing Low risk (no PPD done)

Med-to-High risk (exposure to TB; born/lived/travel to TB endemic countries; medical risk factors)

Date of PPD _____ Results _____ mm

Referred for evaluation to _____

This student has the following problem(s) that may impact his/her educational experience (check all that apply).

- | | | | |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Fine/Gross Motor Deficit |
| <input type="checkbox"/> Emotional/Social | <input type="checkbox"/> Behavior | <input type="checkbox"/> Other | |

Comments/Recommendations _____

Y N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions.** _____

Y N **Immunizations are complete. If no, give reason.** _____

Signature of Examiner (Circle: MD, DO, NP, PA) _____ Date _____

Group Practice _____ Telephone _____ Please print name of Examiner. _____

Address _____ City _____ State _____ Zip Code _____

Please attach additional information as needed for the health and safety of the student. MDPH 02/24/11

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____ Date of Birth: ____/____/____ Sex femalemale

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B <small>(e.g., HepB, HepB-Hib, DTaP-HepB-IPV)</small>	1		Haemophilus influenzae type b <small>(e.g., Hib, HepB-Hib, DTaP-Hib)</small>	1	
	2			2	
	3			3	
		4			
Diphtheria, Tetanus, Pertussis <small>(e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)</small>	1		Measles, Mumps, Rubella <small>(MMR)</small>	1	
	2			2	
	3		Varicella <small>(Var)</small>	1	
	4			2	
	5				
	6		Hepatitis A <small>(HepA)</small>	1	
	7			2	
Polio <small>(e.g., IPV, DTaP-HepB-IPV)</small>	1		Pneumococcal Polysaccharide <small>(PPV23)</small>	1	
	2			2	
	3		Influenza <small>Inactivated (Intramuscular) or Live (Intranasal)</small>	1	
	4			2	
Pneumococcal Conjugate <small>(PCV7)</small>	1		Other	3	
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles			
Mumps			
Rubella			
Varicella*			
Hepatitis B			
* Must also check <i>Chickenpox History</i> box at right.			

Chickenpox History
<p style="text-align: center;">Check the box if this person has a physician-certified reliable history of chickenpox.</p> <p style="text-align: center;"><input type="checkbox"/></p> <p>Reliable history may be based on</p> <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox, • physical diagnosis of chickenpox, or • serologic proof of immunity.

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (*please print*) _____ Date _____

Signature _____

Facility Name _____ Telephone _____

CHARACTER AND PERSONALITY RATINGS

	Below average	Average	Good	Excellent (Top 10%)	No basis for judgment
Leadership					
Cooperation					
Self-confidence					
Warmth of personality					
Sense of humor					
Concern for others					
Energy					
Emotional maturity					
Personal initiative					
Reaction to setbacks					
Respect accorded by peers					
Respect accorded to faculty					

The main factors contributing to the respect accorded the applicant by peers seem to be:		The main factors contributing to the lack of respect accorded the applicant seem to be:	
Superiority in studies		Inferiority in studies	
Accomplishment in activities		Conceit	
Success in athletics		Lack of interest in other people	
Interest in other students		Manners and personal habits	
Leadership in activities		Other (Please specify)	
Personality			

We ask you to give as complete a sketch of the applicant as your knowledge allows. Information concerning the applicant's character, intellect, personality, social, physical, and emotional maturity, outside interests, initiative, drive, and other specific qualities is desired.

Signature _____ Date _____

School _____ Position _____

School Report Regarding Applicant

Name of applicant _____
(First) (Middle) (Last)

Address _____
(Street) (City) (State) (Zip)

Telephone number _____ Grade _____

To the parents/guardians:

Please fill in the above information and sign below. Give one copy of this form to the principal of your school or the guidance counselor and the other copy to a teacher your child has had this year.

I give permission for the release of this information to Pioneer Valley Christian School. I will not seek access to this confidential reference submitted for the purpose of admission.

Signature of parent/guardian _____ Date _____

To the principal, guidance counselor, or teacher:

This student is applying for admission to Pioneer Valley Christian School. A full and candid report from your school is essential if the applicant is to be given fair consideration. Therefore, we ask for careful ratings of and comments about the applicant's character and ability by both a school official and teacher who know this student well. An incomplete report may jeopardize the applicant's admission. All information will be kept confidential.

ACADEMIC RATINGS

	Below Average	Average	Good	Excellent (Top 10%)	No basis for judgment
Ability					
Motivation					
Self-discipline					
Creative qualities					
Growth potential					
Study habits					

Do you section classes according to ability and past achievement? _____ No _____ Yes

If yes, in what subjects is the applicant in advanced sections? _____

In what subjects is the applicant in special sections? Assess, if possible, the applicant's commitment to academic pursuits. (Specific examples will be especially helpful.) _____

CHARACTER AND PERSONALITY RATINGS

	Below average	Average	Good	Excellent (Top 10%)	No basis for judgment
Leadership					
Cooperation					
Self-confidence					
Warmth of personality					
Sense of humor					
Concern for others					
Energy					
Emotional maturity					
Personal initiative					
Reaction to setbacks					
Respect accorded by peers					
Respect accorded to faculty					

The main factors contributing to the respect accorded the applicant by peers seem to be:		The main factors contributing to the lack of respect accorded the applicant seem to be:	
Superiority in studies		Inferiority in studies	
Accomplishment in activities		Conceit	
Success in athletics		Lack of interest in other people	
Interest in other students		Manners and personal habits	
Leadership in activities		Other (Please specify)	
Personality			

We ask you to give as complete a sketch of the applicant as your knowledge allows. Information concerning the applicant's character, intellect, personality, social, physical, and emotional maturity, outside interests, initiative, drive, and other specific qualities is desired.

Signature _____ Date _____

School _____ Position _____

Student Records Release Form

This release form should be completed and signed by the parent or legal guardian and returned to Pioneer Valley Christian School for submission to the student's previous school.

Name of previous school _____

Address _____
(Street) (City) (State) (Zip)

Telephone Number _____ Fax Number _____

The following student has made application to the Pioneer Valley Christian School.

Name _____ Date of birth _____

Please forward the information requested below to Pioneer Valley Christian School:

- Academic records
- Health records
- Recent standardized testing (within one year)
- Psychological and educational evaluations (if applicable)
- Conduct record

I hereby authorize Pioneer Valley Christian School to obtain the record(s) of the above-named student.

Signature of parent or guardian

Date