

Applicant Check List

Keep this form

Epiphany Lutheran School ♦ 8101 Senate, Houston, TX 77040
Phone: 713-896-1843 ♦ Fax: 713-896-7568
www.epiphanylutheranschool.org

Before enrollment in Epiphany Lutheran School is finalized, the following must be complete:

- ❖ Conference with Principal
- ❖ Tour of School
- ❖ Application Form
- ❖ Registration/Tuition fees
- ❖ Emergency Information Form
- ❖ Permission Form
- ❖ Prescription Medication Form *(if needed)*
- ❖ Over-the-Counter Medication Form *(if needed)*
- ❖ Confidential Health History Form
- ❖ **Physician's Statement** Form (Physical Education Consent Form)– Grades K-8
- ❖ **Sports Physical** Consent Form - Grades 5-8
- ❖ Copy of immunizations
- ❖ Copy of birth certificate
- ❖ Copy of court documents *(if applicable to child custody)*
- ❖ Withdrawal form *(from previous school including withdrawal grades and any available academic/testing scores)*
- ❖ Teacher Recommendation form *(given to current teacher and returned)*

Please make every effort to complete the **Application Form** promptly – some classes fill very quickly. You will receive an **Acceptance Letter** after the application process has been completed. If you have any questions, please do not hesitate to call the school office at 713-896-1843 and speak with our principal, Linda Wimberley.

Application

2010-2011

Return this form

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STUDENT INFORMATION

Please type or print

Grade: _____

Name: _____ Preferred Name: _____
Last First Initial

Date of Birth: _____ Female Male
Month Day Year

Student's Social Security Number: _____ - _____ - _____

Student Lives With: (check all that apply)

- Father Stepfather
 Mother Stepmother
 Grandparents Guardian

Please check **ALL** that apply:

- Father deceased Mother deceased
 Parents separated Parents divorced
 Father is remarried Mother is remarried
 Mother has custody Father has custody
 Parents have joint custody

Please provide a copy of any court-ordered custody documents with application.

ETHNIC ORIGIN: (Provision of this information is required by Rev. Proc. 75-50 for the preparation of regulatory reports.)

- Caucasian Hispanic American Indian African American Asian Other

It is the policy of Epiphany Lutheran School that there shall be no discrimination against any student or applicant on the basis of race, color, national origin, sex, age, religion, disability, or political belief in the administration of its educational policies, admissions policies, athletic, food service or other school-administered programs.

SIBLINGS:

Name: _____ Age: _____ School (if applicable) _____

Name: _____ Age: _____ School (if applicable) _____

Name: _____ Age: _____ School (if applicable) _____

INTERESTED IN EPIPHANY:

Please list name of friend or family that would like to receive invitations to special events and/or who would enjoy supporting Epiphany through their time, talents or special gifts.

Full Name _____ Relationship _____

Address _____ City _____ Zip _____

Phone _____ (H) (W) (Cell) (Circle One) Email address _____

For Office Use Only:	Date Received _____	Time Received _____	Previous year report card _____
_____ Test Scores	_____ Immunizations	_____ Fees	_____ Parent Agreement Form
_____ Parent Information Complete	_____ Acceptance Letter Sent	_____ Appointment with Principal	
_____ Testing Date	_____ initials		

Please complete information on back page

PARENT INFORMATION

Father's Name _____	Mother's Name _____
Address _____	Address _____
City _____ Zip _____	City _____ Zip _____
Home Phone _____ - _____ - _____	Home Phone _____ - _____ - _____
Work Phone _____ - _____ - _____	Work Phone _____ - _____ - _____
Cell Phone _____ - _____ - _____	Cell Phone _____ - _____ - _____
Pager # _____ - _____ - _____	Pager # _____ - _____ - _____
Email _____	Email _____
Drivers License No. _____	Drivers License No. _____
Employer _____	Employer _____
Occupation _____	Occupation _____

PARENT'S MARITAL STATUS: (Check One) Married Single

CONTRACTUAL AGREEMENT (must be signed by the individuals listed above who are responsible for school related decisions **and** financial bills)

We the undersigned:

- I. Agree to fulfill all financial obligations
 - A. Tuition and fees will be paid as billed. (billed first of month – due by 15th) Students with tuition in arrears may be withheld from class until payments are current.
 - B. Student's grades and transcript **will not** be issued or released until all applicable tuition and fees are paid.
 - C. In the event of withdrawal or dismissal, all fees are non-refundable and tuition will be charged through the end of the month.
- II. Agree to abide by the Epiphany Lutheran School guidelines as outlined in the family handbook.

_____ Signature	_____ Date	_____ Signature	_____ Date
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TUITION PLAN REQUESTED Paid in full before August 15 (5% discount) 10 monthly payments (August-May)
 12 monthly payments (August-July)

FAMILY WORSHIP LIFE

Church Name _____

Church Address _____

Pastor's Name _____

Check one of the following:

- Lutheran Church/Missouri Synod
- Lutheran Church/Other Synod
- Non Lutheran Church (*please list name of church*) _____
- We have no church membership at this time

Is your family active in your church? Yes No

If you do not have a church home or are inactive in your church, would you be interested in information about Epiphany Lutheran Church? Yes No

Is your child baptized? Yes No

If Yes - Church where Baptized _____

Date of Baptism _____

If Not - would you like information on Baptism? Yes No



8101 Senate Avenue
Houston, TX 77040
713-896-1843

Building hearts that make a home for Jesus

FIRST GRADE: must be 6 by September 1, 2010
KINDERGARTEN: must be 5 by September 1, 2010

REGULAR REGISTRATION – February 22 through May 31st (non-refundable)

\$ 375.00 for the first child with application

\$ 200.00 for each additional child with application

\$ 175.00 Registration fee for each child due July 15th (non-refundable)

LATE REGISTRATION – Beginning June 1st (non-refundable)

\$ 450.00 for the first child with application

\$ 250.00 for each additional child with application

\$ 175.00 Registration fee for each child due July 15th (non-refundable)

Your registration is **not** confirmed until you have received a letter of acceptance from the School Office. **Tuition is due on the 15th of each month.** A late fee of **\$20.00** will be charged if payment is not received by the **20th** of each month. **An additional fee of \$25.00 will be charged for each returned check.** Epiphany reserves the right to dismiss any student whose unpaid balance is delinquent more than two months.

TUITION FEES:

Kindergarten – Grade 8 - \$560 x 10 months = \$5600.00 (Aug-May)

Kindergarten – Grade 8 - \$468 x 12 months = \$5616 (Aug-May)

Epiphany offers a **5% discount** if the total tuition is **paid in full by August 15, 2010.** This discount applies to tuition only.

TUITION ASSISTANCE: Please see Mrs. Wimberley in the school office.

***** Families not current with their financial responsibilities will not be able to register.**

Emergency Information

2010-2011

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Epiphany Lutheran School/Extended Care ♦ 8101 Senate, Houston, TX 77040

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www.epiphanylutherschool.org

Student Name

Grade

In case of an **emergency** when parent/guardian cannot be reached, please contact the following people in the order listed.
Please type or print

1.	Name: _____ Relationship: _____
	Phone #: Home _____ Work _____ Cell _____
2.	Name: _____ Relationship: _____
	Phone #: Home _____ Work _____ Cell _____

I authorize Epiphany Lutheran School to **allow my child to leave the facility** with the following persons after verification of ID:
Please type or print

1.	Name: _____ Relationship: _____
	Phone #: Home _____ Work _____ Cell _____
2.	Name: _____ Relationship: _____
	Phone #: Home _____ Work _____ Cell _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize Epiphany Lutheran School and Extended Care Staff person in charge to take my child to:

Physician _____ Phone # _____

Address: _____

Insurance company _____ Policy/Account/Group # _____

ID Number or Policy Owner Social Security Number _____

Telephone number for insurance claims _____

Hospital: _____ Phone # _____

Nearest hospital (*to be used if no other hospital is listed*)

Cypress Fairbanks Medical Center - 281-890-4285 Address: 10655 Steepletop Dr., 77065

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the last 12 months, any medication prescribed for long-term continuous use, and any other information of which staff should be aware:

(if no conditions apply, please state "NONE")

This information may be disclosed to and used by Epiphany personnel and/or certain of its approved volunteers in the operations of the school and the care, supervision or treatment of students. Specifically, this information may be provided to teachers, day care providers, classroom aides, school nurse, athletic director, coaches, field trip chaperones, drivers, food service providers, and administrators involved in student activities. This information will not be shared with other people or organizations outside of activities sanctioned by Epiphany Lutheran School without the express written consent of the parent or guardian.

Permission Form

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Student Name

Grade

AUTHORIZATION FOR ACTIVITIES

Please Check Appropriate Space

NAME RELEASE

I hereby _____ **GIVE** _____ **DO NOT GIVE** my permission to have my child's name, phone number, home address and a parent's email address in the Epiphany School Directory, which will only be distributed to parents at Epiphany Lutheran School who normally would receive the directory. My signature below also gives my permission for my child's name to be printed in the Epiphany newsletter.

TRANSPORTATION

I hereby _____ **GIVE** _____ **DO NOT GIVE** my consent for my child to be transported and supervised by school faculty/staff or Epiphany parents and/or extended care facility staff on field trips.

WATER ACTIVITIES

I hereby _____ **GIVE** _____ **DO NOT GIVE** my consent for my child to participate in water activities (splash pools/wading pools/swimming pools).

FIELD TRIPS

I hereby _____ **GIVE** _____ **DO NOT GIVE** my consent for my child to participate in field trips.

PHOTO RELEASE

I hereby _____ **GIVE** _____ **DO NOT GIVE** permission for my child to be photographed or video taken in the school, at school functions and on field trips and for those photographs/video to be used in advertisement, displayed on school bulletin boards, the Epiphany Newsletter and on the Epiphany School website. **(When any pictures of students do appear on the website, there will not be any personal identification of any student name.)** I understand that the school staff, professional photographers, news media or other parents may take the photographs. I consent that such photographs and or videos shall be the property of Epiphany Lutheran School, which has the right to duplicate, reproduce and make other uses as Epiphany Lutheran School deems necessary.

Signature of parent or legal guardian

Date

IMMUNIZATIONS

My child's immunization record is on file at the school office or is attached hereto and all immunizations and tuberculosis tests are current.

Signature of parent or legal guardian

Date

MEDICATION/FIRST AID

I hereby _____ **GIVE** _____ **DO NOT GIVE** my consent for other designated staff to administer first aid and/or medication to my child.

Signature of parent or legal guardian

Date

Comments: _____

Prescription Medication Form

2010-2011

Return this form **ONLY** when medication is being sent

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I request and hereby give permission to school personnel to give the prescription medication to my child named below as requested by the physician.

Child's name

Parent signature

Telephone Number

Physician's Statement

Child's name

Date

In order that this school child remain in optimum health and to help maintain maximum school performance, it is necessary that the following medication be given during school hours.

Name of medication

Dosage to be given (amount)

Form of medication: tablet capsule liquid inhalation injection

How often

What times

Purpose

Side effects

Remarks

Printed name of physician

Physician's signature

Physician's Telephone number

Over-the-Counter Medication Form

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DATE: _____

I am requesting and hereby give permission to school personnel to give the following medication during school hours to my child named below in order to maintain my child's physical health and support school performance. To my knowledge, my child has no allergy to this medication.

Child's Name

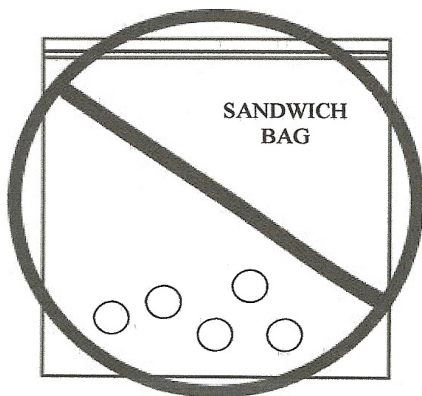
Parent Signature

Telephone Number

Name of Medication

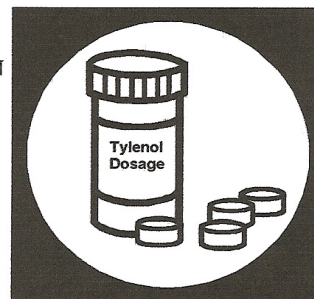
Dosage

Frequency (how often to be given)



IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:

The medication listed above must be supplied by the parent/guardian and must be in the original manufacturer's container with an original label containing dosage instructions. Please do not send OTC medications in baggies or other containers.



Confidential Health History Information Record

2010-2011

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NAME: _____
Last
First
Middle Initial

Date of Birth: _____ Grade Entering: _____

Does your child have any, or has your child had any, problems with any of the medical issues listed below? (Please check where appropriate)

Respiratory/Asthma		Dizziness/Fainting		Heart disease or cardiovascular	
Stomach/Intestinal		Kidney/Bladder		Bone/Joint disease	
Headache/Migraine		Seizures/Convulsions		Diabetes/Weight issues	
Nervousness/Anxiety		Emotional Issues		ADD/ADHD/Hyperactivity	
Prematurity		Birth Defects		Anemia	
Chronic Illness		Hypertension		Other	

If you checked any of the above, please provide an explanation. Please indicate if the student is currently receiving treatment, and if so, please be specific as to the type of treatment, and provide the name of the treating physician.

Does your child have any allergies to the following? (Please check where appropriate)

Bees/Wasps		Ants		Milk/Cheese	
Peanuts/Nuts		Chocolate		Seafood	
Corn/Wheat		Medication		Other	

If you checked any of the above, please provide an explanation of symptoms and effective treatments (creams, medications, allergy shots, etc.)

Has your child ever experienced any of the following? (Please check where appropriate)

Surgery/Operations		Serious Accident/Injury	
Frequent/Recurrent colds		Frequent/Recurrent Ear Infections	
Scarlet Fever		Cold sores	
Hepatitis		Chicken Pox	

If you checked any of the above, please provide dates, and explain.

Does your child experience any of the following? (Please check where appropriate)

Speech Impediment/Language Difficulty	
Vision Trouble/Glasses/Contacts	
Hearing Loss/Hearing Aides	
Physical Handicap/Special needs	
Learning Disability/Hindrance	

Please give a brief explanation:

Does your child take medication on a regular basis? Yes _____ No _____

If **YES**, what medication and what dosage?

Will the student take the medication at school? Yes _____ No _____

If **YES**, please refer to the medication policies and prepare accordingly. Thank You!

Is there anything more about your child or child's health that the school principal should know, or that might be relevant to his/her care?



When was the last time your child was examined by a physician? _____

What was the reason for that examination? _____

Physician's Statement Form
Grades K-8
2010-2011
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Name _____ Grade _____

I have examined the above named child within the past year and find that he/she is physically able to take part in **school activities** and **Physical Education**.

Separate physical form is required for Athletic teams

Comments (if any) _____

Physician's Signature

Date _____

Teacher Recommendation Form

2010-2011

Complete top and give to current teacher

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Student Name _____

Candidate for Grade _____

PARENT OR GUARDIAN

Parent or Guardian: Please write your child's name in the space above and read and sign the following before giving this to your child's teacher.

I understand and agree that the information contained on this Teacher Recommendation Form is confidential and will be used only in the selection of students and will not become part of the student's permanent file. I also agree that this completed form will not be available to students, parents, or anyone outside the Admissions Committee, and I waive any right I may have to see it.

Signature of Parent or Guardian _____

Date _____

TEACHER

Teacher: Please complete this confidential form and return it in the enclosed envelope to the school listed above.

As a current teacher, please evaluate the student based on your direct knowledge of him or her. The Admissions Committee thanks you for your interest, cooperation, and honesty. Your comments will be held in strict confidence and will not be shared with the parents. Please check the appropriate boxes and include comments. **The student's application cannot be processed until this form is received in the Admissions Office.**

Teacher Name (printed) _____

Subject Area _____

Academic Skills

Ratings	Usually	Frequently	Sometimes	Seldom	Comments
Listens to and follows teacher's directions					
Is attentive to group discussions/activities					
Contributes appropriately to group discussions/activities					
Demonstrates ability to work independently					
Perseveres in spite of difficulty					
Works cooperatively					
Enjoys new challenges					
Demonstrates good visual perception					
Demonstrates good auditory memory					
Exhibits problem solving abilities					
Expresses ideas clearly					
Moves easily from one activity to another					
Demonstrates appropriate energy level					
Demonstrates ability to stay on task					
Is self-motivated					

Social Skills

Ratings	Usually	Frequently	Sometimes	Seldom	Comments
Responds positively to constructive criticism					
Establishes friendships easily					
Is comfortable in a group					
Shares well					
Is considerate of others					
Demonstrates self-control					
Communicates needs effectively					
Takes responsibility for belongings					
Is cooperative					
Demonstrates appropriate behavior					
Exhibits emotional maturity					

Physical Development

Ratings	Excellent	Good	Needs Improvement	Comments
Gross motor coordination				
Speech/Articulation				
Fine motor coordination				
General health				

Circle the words that best describe this applicant:

- | | | | | |
|----------------|--------------|-------------|--------------------|------------------|
| Aggressive | Honest | Immature | Disobedient | Self-disciplined |
| Mature | Oppositional | Vivacious | Manipulative | Conscientious |
| Over-protected | Social | Cheerful | Self-centered | Follower |
| Shy | Confident | Irritable | Easily discouraged | Perfectionist |
| Helpful | Witty | Responsible | Motivated | Positive leader |
| Anxious | Articulate | Well-liked | Organized | Negative leader |

Is the student habitually tardy or absent? Yes No If yes, please elaborate: _____

Has the student had any disciplinary problems in the past year? Yes No If yes, please elaborate: _____

RECOMMENDATION

- Highly recommend
- Recommend
- Recommend with reservations because _____

Not recommend because _____

Are parents supportive of school policies? Yes No

Are parents responsive to school suggestions? Yes No

How long have you known student? _____

Form completed by _____ Title _____ Date _____

Name of School _____

Address of School with Zip code _____

Phone _____