

Monroe Bay Christian Academy
New Student Enrollment School Year 2006 / 2007

STUDENT INFORMATION

Will van be needed? () K.G. () C.B.

Student's name _____

Male()Female() Date of Birth _____

Soc. Sec. # ____ - ____ - ____ Home Phone (____) ____ - ____

Home Address _____

Last Grade Completed _____

Last school attended & address _____

FAMILY INFORMATION

Father's Name _____ Home Phone (____) ____ - ____

Address _____ State: _____ Zip: _____ Employed

by _____ Work Phone (____) ____ - ____

Cell # (____) ____ - ____

Mother's Name _____ Home Phone(____) ____ - ____

Address _____ State: _____ Zip: _____ Employed

by _____ Work Phone (____) ____ - ____

Cell # (____) ____ - ____

EMERGENCY CARE

In case of emergency and parent cannot be reached; phone numbers of relatives or friends authorized to pick up your child:

Name _____ Phone# (____) ____ - ____

Name _____ Phone# (____) ____ - ____

I GIVE MBCA PERMISSION TO AUTHORIZE EMERGENCY CARE OR MEDICAL TREATMENT IF NEEDED. I ABSOLVE THE SCHOOL AND DAY CARE FROM LIABILITY TO ME OR MY CHILD BECAUSE OF ANY INJURY TO MY CHILD AT SCHOOL OR DURING ANY ACTIVITY.

Date _____ Signature _____

NOTE: A registration fee of \$45.00 is due and payable each year and must accompany this application. This fee is **Non-refundable** unless the child is not accepted by the school.

MEDICAL HISTORY STUDENT NAME _____

DATE OF LAST PHYSICAL EXAM ____/____/____

Past Diseases – if your child has had any of the following, please state the age when he/she had them.

MUMPS _____	SCARLET FEVER _____	CONVULSIONS _____
MEASLES _____	CHICKEN POX _____	HEART DISEASE _____
ASTHMA _____	PNEUMONIA _____	DIABETES _____
HAY FEVER _____	POLIO _____	EAR DISCHARGE _____
OTHER _____	_____	_____

Recent Disabilities – please check any of the following if noted during the past two (2) years:

4 or more colds yearly - <input type="checkbox"/>	Fainting spells - <input type="checkbox"/>	Shortness of breath - <input type="checkbox"/>
Frequent sore throats - <input type="checkbox"/>	Abdominal pains - <input type="checkbox"/>	Crippling condition - <input type="checkbox"/>
Poor vision - <input type="checkbox"/>	Frequent urination - <input type="checkbox"/>	Hernia (rupture) - <input type="checkbox"/>
Frequent leg pains - <input type="checkbox"/>	Persistent cough - <input type="checkbox"/>	Ringworm - <input type="checkbox"/>
Dizziness - <input type="checkbox"/>	Speech difficulty - <input type="checkbox"/>	Nose bleeding - <input type="checkbox"/>
Frequent sties - <input type="checkbox"/>	Heart condition - <input type="checkbox"/>	Growing pains - <input type="checkbox"/>
Dental defects - <input type="checkbox"/>	Hearing difficulty - <input type="checkbox"/>	Hyperactivity - <input type="checkbox"/>
Disability due to accident or disease - <input type="checkbox"/>	Tires easily - <input type="checkbox"/>	Contact with TB - <input type="checkbox"/>

List any physical defects, allergies, or disabilities your child has: _____

What languages are spoken in your home? _____

**** Please Note:** A copy of you child's immunization records **must** be on file prior to entry.

To be filled out for Pre-school and Daycare Only:

**** Please Note:** A Virginia State Physical Form **must** be completed and turned in prior to entry.

PERSONAL RECORD:

Is your child shy? - <input type="checkbox"/>	Does child suck thumb? - <input type="checkbox"/>
Does child have excessive fears? - <input type="checkbox"/>	Does child have temper tantrums- <input type="checkbox"/>
Does child bite fingernails? - <input type="checkbox"/>	Is child overactive- <input type="checkbox"/>
Does child eat breakfast- <input type="checkbox"/>	What foods does child eat for breakfast? _____

Does your child like school? _____

Other Comments You Wish To Include _____

EMERGENCY CARE RECORD
STATEMENT OF COOPERATION

EMERGENCY CARE:

In case of an emergency, parent or guardian can be reached at:(other than home and work) (____)

Child's Physician

Phone#(____)_____

If parent cannot be reached:

Neighbor_____ Phone(____)_____

Friend _____ Phone(____)_____

Relative_____ Phone(____)_____

Other_____ Phone(____)_____

If your child is in the Day care or Pre-school program, who is authorized to pick him/her up from school?
I give MBAC permission to authorize emergency care or medical treatment if needed. I absolve the school and day care from liability to me or my child because of any injury to my child at school or during any activity.

DATE: _____

PARENT'S SIGNATURE: _____

Book Fees for 2008-2009

Yearly book fees – Grades 1-4 Only \$110.00

Yearly book fees – Grades Preschool-K-5 Only \$50.00

Grades 5-12 – No Yearly Book Fees – Monthly \$30 PACE Fee (average)