



# NORTHSIDE CHRISTIAN SCHOOL

## PRE-SCHOOL & CHILD CARE CENTER

### School Year \_\_\_\_\_

# APPLICATION FOR ADMISSION

### STUDENT INFORMATION

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Preferred

Address: \_\_\_\_\_  
Street City State Zip

Phone: \_\_\_\_\_

Name of Previous School: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

### CHILD MUST BE FULLY TOILET TRAINED

Are there any health factors to consider for this child? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes please explain: \_\_\_\_\_

\_\_\_\_\_

Sleeping/Nap Preferences, Needs, or patterns: \_\_\_\_\_

\_\_\_\_\_

Does this child have any physical, emotional, or academic issue that may affect his/her educational needs?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes please explain: \_\_\_\_\_

\_\_\_\_\_

Is this child currently under any treatment for any physical, emotional, or academic issue? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes please explain: \_\_\_\_\_

\_\_\_\_\_

Achievement level of child's prior schoolwork has been: Above Average \_\_\_\_\_ Average \_\_\_\_\_ Below Average \_\_\_\_\_

Has this child ever been referred, diagnosed, or treated for any of the following:  
\_\_\_\_\_ ADD \_\_\_\_\_ ADHD \_\_\_\_\_ LD \_\_\_\_\_ EBD Other \_\_\_\_\_

If so please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY INFORMATION**

Name \_\_\_\_\_ Father \_\_\_\_\_ Stepfather

Address: \_\_\_\_\_  
Street City State Zip

Phone: // \_\_\_\_\_  
Home Cell

eMail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Church: \_\_\_\_\_

\*\*\*\*\*  
Name \_\_\_\_\_ Mother \_\_\_\_\_ Stepmother

Address: \_\_\_\_\_  
Street City State Zip

Phone: // \_\_\_\_\_  
Home Cell

eMail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Church: \_\_\_\_\_

**SIBLING INFORMATION**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

**Please list the name and address of the person responsible for this child's tuition account:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**EMERGENCY CONTACT**

In case of an emergency and parents/guardians cannot be reached, persons listed are authorized to pick up student:

Name	Phone ( )	Relationship
Name	Phone ( )	Relationship
Name	Phone ( )	Relationship

**CONSENT FOR EMERGENCY TREATMENT**

I hereby give permission for my child be given emergency treatment by a qualified staff member at NCS. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I give permission to release information from my child's file to my physician or to a referral source, and to obtain information from my physician or other professional source in the event of an emergency transfer. In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment, and procedures to be performed for my child be a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health.

I give permission for my child to receive health-promoting screening services provided at NCS, such as vision, hearing, and scoliosis.

**BOTH SIGNATURES ARE REQUIRED, IF APPLICABLE:**

Father/Guardian	Date	Mother/Guardian	Date
-----------------	------	-----------------	------

**TRANSPORTATION AUTHORIZATION** – Persons authorized to pick up my child

Name	Relationship
Address	Phone ( )
Name	Relationship
Address	Phone ( )
Name	Relationship
Address	Phone ( )

