NEW BEGINNINGS CHRISTIAN SCHOOL
Application for Enrollment

Date: _____

Child's Name: _____

Date of Birth: _____

Street Address: _____

City: _____ Zip Code _____

E-Mail Address:_____
Telephone: _____
Father's Name:_____
Place of Employment: _____
Work Phone: _____
Mother's Name: _____
Place of Employment: _____
Work Phone: _____
Please indicate the custodial parent if both parents are not in the residence of the child.
father _____ mother _____

Name of Public School District: _____

(Office Use Only)

Please date and initial the following upon receipt:

_____ Application for Enrollment
_____ Enrollment Survey Form
_____ Authorization Pickup
_____ Financial & Policy Agreement
_____ Parental Statement of Cooperation
_____ Confidential Family History
_____ Health Record
_____ Parent Consent for Record Release
_____ Birth Certificate
_____ Emergency Medical Authorization
_____ Enrollment Fee paid
_____ Entrance / Material Fee paid

ENROLLMENT SURVEY FORM

In the enrollment application process, an interview with the parents and school principal is required. if the child is not already enrolled in our preschool program, the child is also asked to attend the interview.

This is an opportunity for us to get to know one another and for us to mutually evaluate whether or not NBCS is the best situation for your child.

Your deposit holds a space tentatively until enrollment acceptance for your child.

Please answer the following questions:

1. How did you find out about NBCS?_____

   _____

2. Why do you desire that your child be a student at NBCS?

   _____

   _____

3. In what public school district do you reside? _____

4. Do you intend to keep your child in Christian school:

   _____ a. This year only

   _____ b. Through 8th Grade

   _____ c. Undecided

If your child is in 5th grade or above, please have your child answer the following question and sign at the bottom. "Why I want to come to NBCS."

_____
_____
_____
_____
_____

Student's Signature Date

NEW BEGINNINGS CHRISTIAN SCHOOL
AUTHORIZATION PICK UP FORM

Please list three people (other than yourself), their names, and telephone numbers that are allowed to sign your child out from school during the school day.

1. Name _____

   Address _____

   Phone_____

   Relationship_____

2. Name _____

   Address _____

   Phone _____

   Relationship _____

3. Name _____

   Address_____

   Phone _____

   Relationship _____

Name of child _____

_____
Signature of parent/guardian

NEW BEGINNINGS CHRISTIAN SCHOOL
FINANCIAL & POLICY AGREEMENT`

Date: _____

Child's Name: _____

Please fill in the appropriate spaces below.

I hereby declare my intention to enroll the above-named child in _____ grade at New Beginnings Christian School. I have received a copy of the Student Handbook and have been given a full explanation of the school's educational, disciplinary and religious program. I have read the policies, understood them and the services being offered to my child, and agree to abide by them.

SCHOOL TUITION ONLY

I hereby agree to the above items and agree also to pay the tuition of $ _____ per month for ten months, with the first payment due August 1 and the final payment due May 1.

I hereby agree to the above items and agree also to pay the tuition of $_____ per month for twelve months, with the first payment due August 1 And the final payment due July 1.

BEFORE OR AFTER SCHOOL TUITION

I hereby agree to pay $_____ per week for AM / PM daycare services for my child.

I understand that a $25.00 late fee will be imposed for every week my school or $15.00 late fee will be imposed for every week my daycare account is late.
I understand that being two weeks delinquent on any payments is grounds for disenrollment of my child.

_____
Signature of Parent or Guardian

_____
Signature of enrolling staff

I AGREE TO HAVE MY NAME AND TELEPHONE NUMBER INCLUDED ON MY CHILD'S CLASS ROSTER WHICH WILL BE MADE AVAILABLE UPON REQUEST TO ANY PARENT WHOSE CHILD IS ENROLLED IN MY CHILD'S CLASS.
YES ___ NO ____ _____DATE _____
SIGNATURE

PARENTAL STATEMENT OF COOPERATION

I have read the policies of New Beginnings Christian School, I understand them, and will abide by them. I will pay all financial obligations on the designated day. I realize tuition is due regardless of absenteeism or holidays. I understand that failure to pay all fees and tuition in a timely manner is grounds for disenrollment. It is my understanding that the policy for the school is to make no refunds on enrollment or entrance fees.

I give New Beginnings Christian School permission to discipline my child using the discipline procedures as outlined in the discipline policy. And I will support or "back up" the school and teachers to my child. And, I will endeavor to work with the school in full cooperation in all areas regarding my child.

I further agree to hold the school and its agents harmless for any liability to my child or any guardian or parent thereof because of any claims on behalf of my child against the school or any agent thereof because of any injury or alleged injury to my child.

I understand that this statement of cooperation will be in effect for as long as my child attends New Beginnings Christian School and will be kept on file on the premises.

I understand that failure to comply with the policies of New Beginnings Christian School is grounds for disenrollment of my child.

Parent's signatures (both must sign unless only one has guardianship)

Father: _____Date: _____

Mother: _____ Date:_____

Guardian (if other than parent):
_____Date:_____

******* New Beginnings reserves the right to refuse enrollment to any child whose parents or guardian, in the opinion of the administration, indicate the potential for uncooperation.

CONFIDENTIAL FAMILY HISTORY

Date: _____

NAME OF CHILD _____DATE OF BIRTH _____

SEX: MALE ___FEMALE___AGE____YEARS ____MONTHS _____

ADDRESS _____PHONE _____
Street City Zip

MOTHER'S NAME _____AGE _____BIRTHPLACE _____

OCCUPATION _____BUSINESS PHONE _____

NAME OF EMPLOYER _____

BUSINESS ADDRESS _____

EDUCATION (yrs. attended) ELEM. ____HIGH SCHOOL____COLLEGE___

FATHER'S NAME _____AGE ___BIRTHPLACE_____

HOME ADDRESS _____ PHONE _____

OCCUPATION _____BUSINESS PHONE _____

NAME OF EMPLOYER _____

BUSINESS ADDRESS _____

EDUCATION (Yrs. attended) ELEM. ___HIGH SCHOOL____COLLEGE____

DO BOTH PARENTS NOW LIVE WITH CHILD? YES ___NO____
IF NO, ARE BOTH PARENTS PERMITTED TO PICK CHILD UP? ____
IF NO, PLEASE EXPLAIN ON BACK OF FORM

LIST NAMES AND BIRTHDATES OF OTHER CHILDREN IN FAMILY:

NAME_____BIRTHDATE_____NAME_____BIRTHDATE ____

NAME_____BIRTHDATE_____NAME_____BIRTHDATE____

NEAREST RELATIVE _____RELATIONSHIP_____

ADDRESS_____PHONE_____

IS CHILD ADOPTED?_____HAS CHILD BEEN TOLD?_____

NAME OF CHURCH _____

NEW BEGINNINGS CHRISTIAN SCHOOL
492 WILLIAMS RD.

COLUMBUS, OHIO 43207

PARENT CONSENT FOR RECORD RELEASE

TO: ____
____
____

I am the parent/legal guardian of __________________________________
Student's Name

who is _____________years old and the date of birth is _____________.

You are authorized to release all records pertaining to my child to New Beginnings Christian School. This includes, but is not limited to: Placement data, mental aptitude and achievement test data, academic records, health records, psychological reports, discipline reports, etc.

____

____
Parent's Signature date

****

FOR OFFICE USE ONLY

Date request received ______________________________

Date request mailed ________________________________

Emergency Medical Authorization
New Beginnings Christian School
492 Williams Rd., Columbus, Ohio 43207
(614) 497-3815 (614) 497-2171 - Fax

_____ _____
Student's Name Grade

_____ _____
Address Phone

Part I or Part II must be completed.

PART I (TO GRANT REQUEST)
In the event of an emergency, please attempt to contact:
_____at_____
Name of 1st Person to call in an Emergency Phone Number
_____at_____
Name of 2nd Person to call in an Emergency Phone Number

If reasonable attempts to contact the two persons mentioned above are unsuccessful, I hereby give my consent for 1. The administration of any treatment deemed necessary by:
_____at_____
Name of Preferred Physician Phone Number
_____at_____
Name of Preferred Dentist Phone Number

Or, in the event the designated preferred practitioner if not available, by another licensed physician or dentist; and 2. the transfer of their child to
_____
Name of Preferred Hospital
or any hospital reasonably accessible.
This authorization does not include any major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:
_____
_____
_____ _____
Signature of Parent Date
_____
Addres
PART II (REFUSAL TO CONSENT) * Do not complete Part II if you completed Part I
I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or or to:_____
_____

_____ _____
Signature of Parent Date

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT

For Child Care Centers and Type A Family Child Care Homes

Child's Name *(print or type)*	Date of Birth

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

Recommended Immunizations (*enter month, day, and year*)

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐ No Date: _____
Dental: ☐ Yes ☐ No Date: _____
BMI: ☐ Yes ☐ No Date: _____
Hearing: ☐ Yes ☐ No Date: _____
Lead: ☐ Yes ☐ No Date: _____
Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.