

JARABACOA CHRISTIAN SCHOOL
REGISTRATION

Application Date _____

Scholarship: Yes ____ No ____

I. Please complete

CHILD's Name _____ Nickname _____

Previous School _____ Grade Level _____ Report Card _____

Birth Place _____ Birth Date _____ Age _____

Address _____ City _____

Father's Name _____ Nickname _____

Marital Status _____ SSN/Passport # _____

Address (if not the same) _____

Telephone (____) _____ Birth Date _____ Condition of Health _____

Email Address _____ Highest Grade Completed _____

Place of Employment _____

Work Telephone (____) _____ Work Hours _____

Occupation _____ Religious Denomination _____

Mother's Name _____ Nickname _____

Marital Status _____ SSN/Passport # _____

Address (if not the same) _____

Telephone (____) _____ Birth Date _____ Condition of Health _____

Email Address _____ Highest Grade Completed _____

Place of Employment _____

Work Telephone (____) _____ Work Hours _____

Occupation _____ Religious Denomination _____

Emergency Contact Information (must provide two contacts)

Name _____ Relationship to Child _____

Address _____

Home Phone (____) _____ Work Phone (____) _____

Name _____ Relationship to Child _____

Address _____

Home Phone (____) _____ Work Phone (____) _____

II. Please check if the problem is present.

- _____ Developmental delay
- _____ Eating Problems
- _____ Failure to follow instructions of authority figures
- _____ Hyperactivity/Attention problems
- _____ Language and speech problems
- _____ Peer relationship problems
- _____ School attendance problems
- _____ School learning/academic problems
- _____ Other (specify)

III. Does your child have, or has he/she had, any of the following physical symptoms more frequently than most children? If so, please check.

- | | | |
|------------------------------------|--------------------|----------------------|
| _____ Allergies | _____ Headaches | _____ Stomach aches |
| _____ Thumb sucking | _____ Dizzy spells | _____ Seizures |
| _____ Hyperactivity | _____ Asthma | _____ Stuttering |
| _____ Eye strain/difficulty seeing | _____ Head Lice | _____ Ear Infections |

IV. Please provide the following information.

Child's Height _____ Weight _____ Does he/she use glasses? Yes _____ No _____

Medication(s) currently being taken:

- | | |
|------------------------|------------------------|
| 1) _____ Time(s) _____ | 2) _____ Time(s) _____ |
| 3) _____ Time(s) _____ | 4) _____ Time(s) _____ |

Is your child allergic to any medication? Yes _____ No _____ If yes, which one(s) _____

Please describe any other medical problems _____

Please provide the following documents for child:

- 1. Birth Certificate or Passport**
- 2. Immunization Record**
- 3. Previous Report Card/School Records**
- 4. Passport Photos (available at JCS)**