PHOENIX RISING FREE SCHOOL
where learning comes naturally

ENROLLMENT APPLICATION

STUDENT INFO

Child's Last Name: First Name: MI

Birth date: Current Age: Gender: ❍Male ❍Female

Street Address:

City: State: Zip Code: Telephone:

Program Choice: DAY: ❍ Standard ❍ Extendend YEAR: ❍ Standard ❍ Extended

Last School Attended: Phone: Grade:

Does student currently have an: ❍IEP ❍504 Has student previously had an: ❍ IEP ❍ 504

Has Student received additional services: ❍OT ❍PT ❍ST ❍other:

HEALTH INFO

Physician's Name: Physician's Phone

Health Concerns/Diagnosis/Allergies:

Dietary Restrictions: ❍ None ❍Dairy Free ❍Gluten Free ❍ Casein Free ❍ Other:

Current Medications: ❍None ❍ Specify:

Past Medications: ❍None ❍ Specify:

Hearing Status: ❍ Good ❍ Not Tested ❍ Impaired ❍ Aids ❍ APD Tubes: ❍ Past ❍ Present

Vision Status:❍ Good ❍ Not Tested ❍ Impaired ❍ Glasses/Contacts ❍ APD ❍ Vision Therapy

FAMILY INFO

Student Lives with: ❍Both Parents ❍Mother ❍Father ❍P/T Mother &Father ❍Other:

Custody Arrangements: Please attach a current copy of any joint/exclusive custody agreements for this child.

Special Custody Issues:

Mother's Last Name: First Name: MI

Address: (if different)

Home Phone: Cell Phone: Work Phone:

Email:

Employer: Occupation:

Emp. Address: City: State: Zip:

Father's Last Name: First Name: MI:

Address: (if different)

Home Phone: Cell Phone: Work Phone:

Email:

Employer: Occupation:

List Siblings and Others Living in Home

Name: Relationship: Age: Grade: School:

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Name: Relationship: Age: Grade: School:

EMERGENCY CONTACTS Please list the name and number for two people who have agreed to be contact when both parents cannot be reached.

1)Name: Relationship: Phone: .

2)Name: Relationship: Phone: .

DEVELOPMENTAL INFO

Pregnancy: ❍ Full Term ❍ Premature: # weeks ❍ Late: # of weeks Birth Weight: lbs oz

Delivery: ❍ No Complications ❍ Vaginal ❍ C-Section ❍ Breech .

Complications: .

Surgeries/Hospitalizations: .

Development Stages: Please list age or EARLY – AVERAGE – LATE .

Rolling: Sitting: Crawling: Was it cross crawl or some variation? .

Walking: Eating Pureed Foods: Eating "Cheerio" Type Foods: Self Feeding: .

Babble: First Words: Phrases: Potty Trained: Dry at Night: Dress Self .

Family History: Do any family members have a history of the following? .

Learning Difficulty: .

Dyslexia or Reading Problems: .

Obsessive Compulve Disorder (OCD): .

ADD/ADHD: .

Anxiety: : .

Addiction: : .

Diagnosis/Condition	Suspected	Diagnosed	Medicated/Treated
ADD/ADHD			
Dyslexia / Reading Issues			
Anxiety			
Autism			
Cerebral Palsy			
Seizures			
Poor Balance/Coordination			
Delayed Language/Articulation Disorders			
Perfectionism			
Strong Fears			
Snoring/ Sleep Apnea			
Other:			

STUDENT INTERESTS

Favorite Book: _____ **Favorite Movie:** _____.

FavoriteCharacter: _____ **Favorite Activity:** _____.

Favorite Color: _____ **Favorite Animal:** _____.

Foods: Favorite: _____ **Dislikes:** _____.

Dreams: _____.

Unique Qualities: _____.

Why are you looking at an alternative to Public/Traditional Private Schools?

_____.

_____.

How does the student currently occupy their time?

_____.

Describe your experience raising your child:

_____.

_____.

_____.

ATTACH PHOTO(s) HERE

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FIRST AID PRODUCT RELEASE

Dear Parents,

Occasions arise where your child may require first aid during the school day. For these occasions, our school's health office maintains a limited supply of first aid products. Please complete the following form and return it to the school office with enrollment package.

Child's Name:	Phone:
Birth Date:	Grade (2011-2012 School Year):

I/we give permission for the above named student to have first aid administered when deemed necessary.

Initial any/all items your child may receive.
Note: No medication may be given without parental consent and/or a doctor's order (if applicable).
Parent must also provide the medication. A medication consent form is available in the school office.

Initial below	First Aid Products	Initial below	First Aid Products
	Bacitracin Ointment *(antibiotic ointment for abrasions)*		**Petroleum Jelly** *(for chapped or dry lips)*
	Benadryl Cream/Gel *(itching)*		**Benzalkonium Chloride** *(antiseptic for abrasions)*
	Sterile Eye Wash *(Purified Water)*		**Ice Pack to be applied** *(bumps, bruises and sprains)*
	Sunblock Lotion *(if a child doesn't provide his/her own lotion)*		**Other:**

I authorize the Health Aide or individual designated by the Principal to be my agent to administer to my child the above noted first aid products.

Parent's Name:		Date:
Signature:		

NOTES TO SCHOOL