



## New Life Christian Academy Enrollment Procedures

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K3 must be 3 years of age by September 1<sup>st</sup> and *fully* potty trained

K4 must be 4 years of age by September 1st

K5 must be 5 years of age by September 1st

1<sup>st</sup> Grade must be 6 years of age by September 1st

Please read through the registration information carefully. The following information is needed for your child to begin the enrollment process. Please understand that without a complete enrollment packet and application fee, we are unable to schedule an entrance exam or interview.

**Notes:** New students may not be more than 1 year behind his/her age appropriate grade. NLCA will accept foreign exchange students on an individual case basis.

- Student Enrollment Application
- Enrollment Questionnaire
- Pastoral Recommendation
- Teacher(s) Recommendation
- Principal/Director Recommendation
- Copy of most recent Report Card (*if applicable*)
- Immunization Records
- Physical Form
- Copy of SS card
- Copy of Birth Certificate
- Student Emergency Authorization
- Student Record Release Form
- Legal Documents (*if applicable*)
- Copy of Parent(s)' or Legal Guardians' ID
- Application Fee

Upon the submission of a complete enrollment packet, the admissions office will schedule a date / time for the entrance exam.

1. The Administrative Interview will be scheduled upon the completion of the Exam
2. The Registration fee is to be paid on the date of the interview.
3. Attend the Orientation, if enrollment is at the beginning of the year. If enrollment is during the year, view the orientation video.

Note: In submitting the Application for Enrollment, it is my desire for my child to complete this school year. It is also my understanding that the school policy is that refunds are not given for registration or any other fees.



## STUDENT ENROLLMENT APPLICATION

### NEW LIFE CHRISTIAN ACADEMY

For Office Use Only  
Student ID # \_\_\_\_\_

#### Section 1: STUDENT INFORMATION

Date: \_\_\_\_\_ School Year: \_\_\_\_\_ to \_\_\_\_\_ Grade Applying For \_\_\_\_\_

Full Legal Name: \_\_\_\_\_ Goes By: \_\_\_\_\_

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

SSN: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please Check One:  Asian / Pacific  Black/Non-Hispanic  Caucasian  Hispanic  Other \_\_\_\_\_

#### Section 2: PARENTAL INFORMATION (Please complete for legal guardians with whom the child lives)

(1) \_\_\_\_\_ (2) \_\_\_\_\_

Father Step-Father Grandfather Other \_\_\_\_\_ Mother Step-Mother Grandmother Other \_\_\_\_\_

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

Check if same as above

Check if same as above

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work # \_\_\_\_\_ Work # \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

*In the event the child lives between 2 households, the mother will be the primary contact until we receive legal documents stating otherwise.*

#### Section 3: STUDENT PICK UP

Please list the names of the individuals authorized to pick up your child from school.

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

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

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



NEW LIFE CHRISTIAN ACADEMY  
PRE-SCHOOL ENROLLMENT QUESTIONNAIRE

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

In regards to your child, please check the correct answer, and answer all questions truthfully.

Inaccurate, or falsified, information may lead to your child's dismissal from the Academy.

**For all questions in which a "Yes" is checked, except question #1, please provide details below.**

1. Is your child *fully* potty trained  Yes  No
2. Has your child ever been placed in child protective custody?  Yes  No
3. Is your child on prescribed or maintenance medication?  Yes  No
4. Has your child ever been diagnosed with ADD, ADHD, or any other type of medical condition?  Yes  No
5. Has your child ever experienced problems with adapting to change?  Yes  No
6. Has your child ever been administratively removed from a childcare center  Yes  No

Please provide details for all above "Yes" boxes:

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I certify that I am the legal parent/guardian of the student named on this questionnaire and that I have answered all questions truthfully to the best of my knowledge. I understand that information intentionally withheld may result in my child's dismissal from the Academy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# New Life Christian Academy

6622 Highway 90 West

San Antonio, TX 78227

(210) 679-6001 Office (210) 679-6080 Fax

www.newlifeca.org

## STUDENT EMERGENCY AUTHORIZATION

*An emergency card must be on file for each student*

### Student Information

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

Grade \_\_\_\_\_

M

F

Student's Legal Name \_\_\_\_\_

Student's Home Address \_\_\_\_\_

Student's Home # \_\_\_\_\_

S.S. # \_\_\_\_\_

### Parent / Guardian

### Information

New Life Christian Academy requires a telephone number where a parent/guardian can be reached in case of an emergency.

Father/Legal Guardian \_\_\_\_\_

Place of Business \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Mother/Legal Guardian \_\_\_\_\_

Place of Business \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Please list names of other adults who are authorized to pick up your student and make important decisions if necessary.

( )

( )

( )

Name of Adult #1

Relationship

Home Phone

Work Phone

Cell Phone

( )

( )

( )

Name of Adult #2

Relationship

Home Phone

Work Phone

Cell Phone

**Medical Information**

Please complete the following. Unless otherwise restricted by law, special health problems will be shared with appropriate staff and faculty to provide the best possible care for your student. Check all that apply.

Student Physician Address City State Telephone ( )

Preferred Hospital: Telephone ( )

New Life Christian Academy does not assume any financial responsibility, but will provide or arrange emergency care. By signing this card you are giving the appropriate school personnel authority to call EMS, to transport, or to obtain medical care if you or the alternate adult cannot be reached.

**CONDITION**

List any other health condition that would be significant in the care of your child at school.

**Asthma****Diabetes****Does the child take medication?**

Yes  No If yes, please explain

**Epilepsy/Seizure Disorder** Date of last seizure:**Heart:** Type of condition

Allergies-Type (food, insect, other)  
Reaction  Mild  Severe

**Updated Immunizations:**  Yes  No If yes, when:

**Epipen:**  Yes  No

**Vision:** Glasses Contacts Visual Impairment

**Has child had a hearing test:** Yes No If yes, when?

**Scoliosis:** Date Diagnosed: Treatment

**If your child has a fever requiring medication, you would like him/her to receive:**

I hereby grant permission for emergency medical/nursing care to be given by the attending physician and/or school personnel. I also give permission for EMS to be called and/or my child to be transported as necessary by school personnel. I will NOT hold New Life Christian Academy financially responsible for the emergency care and/or transportation of my child.



## CONFIDENTIAL DAYCARE RECOMMENDATION FORM

**Applicant should complete this section and then give this form to the Teacher or other authorized personnel.**

Applicant's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_ DOB \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**The above named student has applied for admission to New Life Christian Academy. In order to make an intelligent selection of students and to adequately meet their needs, we must obtain as much information as possible before he/she comes to us. We ask that you complete this form only answering the questions about which you have knowledge. The information you give will be kept in strict confidence. Once completed please mail or fax to:**

New Life Christian Academy  
6622 Highway 90 West  
San Antonio, TX 78227  
210-679-6080 (Fax)

Name of Daycare \_\_\_\_\_ Name of Teacher (print) \_\_\_\_\_

In what capacity and for how long have you known the applicant? \_\_\_\_\_

**Please indicate your rating by numbers in the right-hand column. Use a question mark where you have insufficient evidence.**

	5	4	3	2	1	RATING
PARENTAL SUPPORT	Exceptional	Above Average	Average	Sometimes Unsupportive	Very Unsupportive	
EMOTIONAL STABILITY	Extremely Well Balanced	Well Balanced	Usually No Problems	Some Problems	Many Problems	
SOCIAL SKILLS & PEER RELATIONSHIPS	Well Liked	Liked	Accepted, but not sought out	Some difficulty in cultivating	Prefers solitary play	
MENTAL DEVELOPMENT	Very mature for age	Above Average	Average	Immature for Age	Very Immature for Age	
INITIATIVE, CURIOSITY	Outstanding	Above Average	Average	Occasionally weak or lacking	Very Weak	
MOTOR SKILLS	Excellent Hand-eye Coordination	Good hand-eye coordination	Average	Some difficulty in using items	Difficulty in Grasping & holding items	

Do you recommend this student to attend New Life Christian Academy?     Yes  No     Reservation \*

\* \_\_\_\_\_

Teacher's Signature \_\_\_\_\_ Date \_\_\_\_\_



## CONFIDENTIAL DIRECTOR RECOMMENDATION FORM

*Parents should complete this section and then give this form to the Director or other authorized personnel.*

Applicant's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_ DOB \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

The above named student has applied for admission to New Life Christian Academy. In order to make an intelligent selection of students and to adequately meet their needs, we must obtain as much information as possible before he/she comes to us. We ask that you complete this form only answering the questions about which you have knowledge. The information you give will be kept in strict confidence. Once completed please mail or fax to:

***New Life Christian Academy 6622 Hwy 90W San Antonio, TX 78227 210-679-6080 Fax***

Name of School \_\_\_\_\_ Principal's Name (print) \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Length of time acquainted with student \_\_\_\_\_

This student has been sent to my office for disciplinary problems:  Often  Seldom  Never

This student has been suspended \_\_\_\_\_ times.

Has the student been expelled and therefore not eligible to return next year?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Does this candidate have any personal circumstances that will interfere with academic achievement? \_\_\_\_\_

Please indicate your rating by numbers in the right-hand column. Use a question mark where you have insufficient evidence.

	5	4	3	2	1	RATING
INTEGRITY	Exceptional	Above Average	Honest	Weak or Questionable	Dishonest	
BEHAVIOR	Outstanding	Above Average	Average	Marginal	Intolerable	
FOLLOWS DIRECTIONS	Outstanding	Very Good	Average	Sometimes	Does not follow Directions well	
RESPECT FOR AUTHORITY	Extremely Respectful	Very Respectful	Respectful	Sometimes Disrespectful	Very Disrespectful	
PARENTAL SUPPORT	Exceptional	Very Good	Average	Sometimes Unsupportive	Very Unsupportive	
SUMMARY AS A PERSON	Outstanding	Excellent	Average	Below Average	Poor	

Do you recommend this student to attend New Life Christian Academy?  Yes  No  Reservation \*

\* \_\_\_\_\_

Director's Signature \_\_\_\_\_ Date \_\_\_\_\_



# PASTORAL RECOMMENDATION FORM

*Reaching this Generation  
Through Christian Education*

This section should be completed by the applying student/family.

## SECTION 1.

Name of Student \_\_\_\_\_ Family Name \_\_\_\_\_

Church Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Pastor's Name \_\_\_\_\_ Years Attended \_\_\_\_\_

## SECTION 2.

**TO BE FILLED OUT BY AUTHORIZED PERSONNEL (CONFIDENTIAL)**

Your recommendation is important. Once completed, please return this form to New Life Christian Academy, 6622 Hwy 90W, San Antonio, TX 78227. You may FAX the completed form to the Admission office at (210) 679-6080

### Member of the Church:

FATHER:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
MOTHER:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
STUDENT:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

### Attendance:

FATHER:	<input type="checkbox"/> Regularly	<input type="checkbox"/> Occasional	<input type="checkbox"/> Seldom
MOTHER:	<input type="checkbox"/> Regularly	<input type="checkbox"/> Occasional	<input type="checkbox"/> Seldom
STUDENT:	<input type="checkbox"/> Regularly	<input type="checkbox"/> Occasional	<input type="checkbox"/> Seldom

Family Financially supports the church:  Yes  No  Unknown

### Please check all other activities/ministries in which the parents/student is involved:

	<b>P</b>	<b>S</b>		<b>P</b>		<b>P</b>	<b>S</b>
Choir/Music Ministry	<input type="checkbox"/>	<input type="checkbox"/>	Men's/Women's Ministry	<input type="checkbox"/>	Children's Ministry	<input type="checkbox"/>	<input type="checkbox"/>
Youth Group Lead	<input type="checkbox"/>	<input type="checkbox"/>	Sunday School Teacher	<input type="checkbox"/>	Bible Study	<input type="checkbox"/>	<input type="checkbox"/>

Other \_\_\_\_\_

Pastor's Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_



# PREPARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY



This **MEDICAL HISTORY FORM** must be completed annually by parent (or guardian) and student in order for the student to participate in **TAPPS** athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

STUDENT NAME (PRINT): \_\_\_\_\_

GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ PARENT CELL PHONE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE LEVEL: \_\_\_\_\_

PERSONAL PHYSICIAN: \_\_\_\_\_

PHYSICIAN PHONE: \_\_\_\_\_

***In case of emergency contact:***

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

Explain any "YES" answers on a separate piece of paper. Please circle questions for which you have no answer. Any "YES" answer to questions 1- 28 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physicians assistant, chiropractor or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

	YES	NO
1. Have you had a medical illness or injury since your last checkup or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized overnight in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you get tired more quickly than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any family member or relative died of heart problems before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has any family member or relative died of sudden unexpected death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any family member been diagnosed with Long QT Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has any family member been diagnosed with Marfan's syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had a severe viral infections (myocarditis, mononucleosis, etc) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
19. Has a physician ever denied or restricted your participation in sports for any heart problem?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever experienced a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had numbness in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
25. Are you missing any paired organs?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you presently under a doctor's care?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you currently taking any prescription or nonprescription medications or inhalers?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have you ever been dizzy before or during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever become ill after exercising or working in the heat?	<input type="checkbox"/>	<input type="checkbox"/>

- |   | YES                                | NO                              |                                     |                               |
|---|------------------------------------|---------------------------------|-------------------------------------|-------------------------------|
| 32. Have you ever had any problems with your eyes or vision?                                      | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 33. Have you ever gotten unexpectedly short of breath with exercise?                              | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 34. Do you have asthma?   | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 35. Do you have seasonal allergies that require medical treatment?                                | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 36. Do you use any special protective or corrective equipment?                                    | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 37. Have you ever had a sprain, strain or swelling after injury?                                  | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 38. Have you ever broken or fractured any bones?  | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 39. Have you ever dislocated any joints?  | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 40. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints?    | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| If yes, please check the appropriate box and explain on separate sheet of paper.                  |                                    |                                 |                                     |                               |
| <input type="checkbox"/> Head   | <input type="checkbox"/> Shoulder  | <input type="checkbox"/> Wrist  | <input type="checkbox"/> Thigh      | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Neck   | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Hand   | <input type="checkbox"/> Knee       |                               |
| <input type="checkbox"/> Back   | <input type="checkbox"/> Elbow     | <input type="checkbox"/> Finger | <input type="checkbox"/> Shin/ Calf |                               |
| <input type="checkbox"/> Chest  | <input type="checkbox"/> Forearm   | <input type="checkbox"/> Hip    | <input type="checkbox"/> Ankle      |                               |
| 41. Do you want to weigh more or less than you do now?  | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 42. Do you lose weight regularly to meet weight requirements for you Extra-Curricular Activities? | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 43. Do you feel stressed out?   | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |
| 44. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?         | <input type="checkbox"/>           | <input type="checkbox"/>        |                                     |                               |

***Females Only***

45. When was your first menstrual period? \_\_\_\_\_
46. When was your most recent menstrual period? \_\_\_\_\_
47. How much time elapses from the start of one period to the start of another? \_\_\_\_\_ days
48. How many periods have you had in the last year? \_\_\_\_\_
49. What was the longest time between period in the last year? \_\_\_\_\_ days

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of accident still remains. Neither the **Texas Association of Private and Parochial Schools**, nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school, TAPPS, and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, in between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the authorities of such illness or injury.

***I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful and complete responses could subject the student in question to penalties determined by the Texas Association of Private and Parochial Schools.***

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT / GUARDIAN NAME (PRINT): \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION



STUDENT NAME (PRINT): \_\_\_\_\_  
 GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ % BODY FAT: \_\_\_\_\_  
 PULSE: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_/\_\_\_ (\_\_\_/\_\_\_, \_\_\_/\_\_\_) Brachial blood pressure while sitting  
 VISION: R 20/\_\_\_ L 20/\_\_\_ CORRECTED: YES \_\_\_ NO \_\_\_ PUPILS: EQUAL \_\_\_ UNEQUAL: \_\_\_

In keeping with the requirements of the Texas Association of Private and Parochial Schools, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation in the first and third years of high school. This form must be completed if there are yes answers to specific questions on the student's annual **MEDICAL HISTORY FORM**.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIAL*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart- Auscultation of the heart in supine position			
Heart- Auscultation of the heart in standing position			
Heart- Lower extremity Pulse			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's Stigmata			

\*Initials for station -based examination only

MUSULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIAL*
Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot			
Other			

**CLEARANCE**

Cleared for participation

Cleared for participation after completing evaluation/ rehabilitation for: \_\_\_\_\_

Not cleared for participation

Recommendations: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_



# NEW LIFE CHRISTIAN ACADEMY

## EAGLE ENHANCEMENT FORM

Student Name	“Goes By”	Grade
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Parent/Guardian #1 Name	Relationship
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Address	City	State	Zip
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Home Number	Work Number	Cell Number
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Parent/Guardian #2 Name	Relationship
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Address	City	State	Zip
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Home Number	Work Number	Cell Number
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

In the case of an Emergency please contact the following:

Name	Relationship	Contact #
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

I authorize the following individuals to pick my son/daughter up from E.E.

(A copy of the driver's license must be provided)

Name	Relationship	Contact #
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Please list any pertinent information that our staff should know about.

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---

\_\_\_\_\_  
Parent/Guardian #1 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian #2 Signature

\_\_\_\_\_  
Date

**New Life Christian Academy  
Elementary School Supply List  
2010 – 2011**

*The count for each item is 1 unless otherwise indicated*

**Early Education- General**

Backpack – no wheels  
Tri-Fold Nap Mat  
Small Blanket  
Pillowcase [no pillow] for Mat – *king size*  
Plastic Pocket Folders – 2  
Plastic School Supply Box  
Box of #2 Pencils (12 ct)  
Large Coloring Book  
Child Safety Scissors  
Boxes of Tissue - 2

**Early Education - Specifics**

**Pre-K3**

Box of 8 Jumbo Crayons (*primary colors*) - 2  
Glue sticks – 2

**Pre-K4**

Box of 16 ct Crayons  
Bottle of Glue – *large*

**Kinder**

Box of 24 ct Crayons  
Bottle of Glue - *large*