FAYETTEVILLE STREET
CHRISTIAN SCHOOL
EST 1970

Registration Payment Enclosed YES ____ Amount _____ Ck # _____ Cash _____
(Office Use Only)

Date: _____ School Year: _____ Grade Level: _____

Student Full Name: _____
Last First Middle Preferred Name

Home phone: _____ Student cell phone: _____

Address: _____

_____ County _____
City State Zip Code

Date of Birth: _____ Gender: _____ Race: _____ Blood Type: _____

Allergies: _____ Medication: _____

Any type of disability: _____

Previous school attended: _____

Insurance and Medical Contacts (REQUIRED)

Insurance Company: _____ Phone: _____

Policy Holder: _____ ID number _____

Name of Student's Doctor: _____ Office Phone: _____

Name of Student's Dentist: _____ Office Phone: _____

Hospital: _____ Phone: _____

Emergency Contacts (other than parents – one name per line)

Contact Name: _____ Relation: _____

Home Phone: _____ Business Phone: _____ Mobile Phone: _____

Contact Name: _____ Relation: _____

Home Phone: _____ Business Phone: _____ Mobile Phone: _____

Father's Information: Pastor: _____ Alumni: _____ Supporting Church Member: _____

Father's Name: _____
Last First Middle Preferred Name

Marital Status: _____ E-mail: **(required)** _____

Address: _____
Street City State Zip

Home Phone: _____ Mobile: _____

Employer: _____ Job Title: _____

Business Phone: _____ Ext._____

Church Regularly Attending: _____

Emergency Contact: Yes ___ No ___ Allowed to pick up child: Yes ___ No ___

Mother's Information: Alumni: _____ Supporting Church Member: _____

Mother's Name: _____
Last First Middle Preferred Name

Marital Status: _____ E-mail: **(required)** _____

Address: _____
Street City State Zip

Home Phone: _____ Mobile: _____

Employer: _____ Job Title: _____

Business Phone: _____ Ext._____

Church Regularly Attending: _____

Emergency Contact: Yes ___ No ___ Allowed to pick up child: Yes ___ No ___

Will your child need extended care? _____ **If yes, complete the Extended Care Enrollment form and attach.**

All families paying tuition and fees must enroll with FACTS. Visit fscspatriots.org to enroll with FACTS.

I wish to pay on the 12 month plan July-June _____ I wish to pay on the 10 month plan August-May _____

Authorization For Use of Pictures – Fayetteville Street Baptist Church (FSBC) and/or Fayetteville Street Christian School (FSCS) are hereby authorized to take or permit pictures to be taken of our family and/or my child/children for the purpose of public relations (newspapers, its web site, and/or on television) for FSBC and/or FSCS (will list Names Only-if necessary-associated with the picture). Yes ___ No ___

I agree the school has permission to provide first aid treatment. Yes ___ No ___

I agree the school may authorize the physician/hospital of his/her choice to provide emergency care in the event student's doctor/dentist contacts cannot be reached. Yes ___ No ___

I have **signed and attached** the NCCSA Liability Waiver Form. Yes ___ No ___

My child has permission to participate in class approved field trips. Yes ___ No ___

I have read the **Student Handbook** and will abide by all policies, rules, and regulations therein. Yes ___ No ___

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Student Information

Teacher & Grade: _____ School year: _____

Student's Name: _____ Birthdate: _____

Address: _____

Phone number: _____ Student's cell number: _____

Important medical information: _____

_____

Allergies: _____

Father's Name: _____ Phone number: _____

Cell number: _____ Work number: _____

Address: _____

Email: _____ Job/Occupation: _____

Mother's Name: _____ Phone number: _____

Cell number: _____ Work number: _____

Address: _____

Email: _____ Job/Occupation: _____

For Divorced parents or legal guardians:

Who has custody of this student? _____ Court documents required to be on file in office

Student will be picked up at (please circle one): Car Riders or Aftercare

Student's interests/hobbies: _____

_____

Emergency Contacts (when parents cannot be reached)

Name: _____ **Relationship to student:** _____

Phone number:_____ **Cell number:** _____

Name: _____ **Relationship to student:** _____

Phone number:_____ **Cell number:** _____

Local Physician's Name: _____

Address:_____ **Phone number:** _____

Local Dentist's Name: _____

Address: _____ **Phone number:** _____

In case of accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may take whatever arrangements seem necessary.

The following is a list of people who may pick up my child from school. I realize that NO ONE ELSE may pick them up unless authorized by me and if the staff person responsible for my child does not recognize them, they may be asked to produce a photo ID.

1._____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

_____ (student's name) has my permission to participate in class field trips. ___ yes ___ no

I understand and give my permission to FSCS that my child and/or his voice may appear in printed material, photographs, and visual and/or audio recordings from the school. _____ yes _____ no

Parent/guardian signature: _____

Date: _____

This form is to be kept on file with student's classroom teacher

NORTH CAROLINA CHRISTIAN SCHOOL ASSOCIATION

Liability Waiver Form

This Liability Waiver Form must be completed and signed by the parent or guardian for each student before participation in any ***NCCSA Event.*** *The original must be on file in the school office.*

PARENT/GUARDIAN RELEASE

FOR AND IN CONSIDERATION OF the mutual promises, covenants, conditions, representations, and warranties contained herein, and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, it is agreed as follows:

The undersigned hereby releases and forever discharges the North Carolina Christian School Association (NCCSA) along with all of its agents, employees, directors, officers, assigns, and attorneys, from any and all claims, demands, actions, causes of action or suits arising out of any injuries, known or unknown, which have resulted or may in the future result from any NCCSA-sponsored event or associated activity that takes place at any location approved by the North Carolina Christian School Association.

The undersigned hereby assumes all risk of injury associated with any such event and fully indemnifies and holds harmless the NCCSA along with its agents, employees, directors, officers, assigns, and attorneys, from and against each and every liability, loss, cost, damage, and expense, including attorney's fees, which the NCCSA along with its agents, employees, directors, officers, assigns, and attorneys may incur as a result of any NCCSA-sponsored event or associated activity that takes place at any location approved by the North Carolina Christian School Association.

The undersigned expressly agrees that this release, waiver, and indemnity agreement is intended to be as broad and inclusive as permitted by the laws of the State of North Carolina and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

This release contains the entire agreement between the parties hereto and the terms of this release are contractual and not a mere recital.

THE UNDERSIGNED HAS **CAREFULLY READ THE FOREGOING RELEASE, WAIVER, AND INDEMNITY AGREEMENT, KNOWS THE CONTENTS THEREOF, AND SIGNS THIS DOCUMENT AS HIS/HER OWN FREE ACT.** THIS IS A LEGALLY BINDING AGREEMENT WHICH THE UNDERSIGNED HAS READ AND UNDERSTANDS.

This liability waiver/release applies to the following participating student:

Student's Name: _____

who is currently enrolled in the following NCCSA member school:

School Name: _____

School Address: _____

Street City ZIP

Date: _____

_____

Parent/Guardian's Signature **Parent/Guardian's Printed Name**

Notice to sponsoring school: *A parent or guardian of the named student must sign this document before such student can participate in any NCCSA-sponsored event.*

***The NCCSA reserves the right to periodically perform random checks on schools to make sure their forms are current. Schools found out of compliance with these policies will be subject to a $100 fine and/or forfeiture of categories entered.**

PPS-2K Rev. 1/11

NORTH CAROLINA
KINDERGARTEN HEALTH ASSESSMENT REPORT

(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

Personal Data *Please bring your child's shot records with you to this visit *

PARENT COMPLETE

Please Print Clearly - See other side for more required information. Please present completed form to your child's school.

Child's Name _____ _____ _____
(Last) (First) (Middle)

Birth Date: ____/____/ 20 ____ (mm/dd/yyyy)

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Yes	No	
☐	☐	Are you concerned about your child's health, weight, development or behavior?
☐	☐	Does anyone in your family have a condition that has affected their health, weight, development or behavior? **(Please explain in the comments section)**
☐	☐	Has your child been seen by a provider for any health, weight, development or behavior concern?
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC. Signature: _____ **Date:** _____

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

☐ **No Recommendations, Concerns or Needs** ☐ **Requesting School Follow Up**

☐ **Medication**
- ☐ Child takes medicine for specific health conditions:
  List medication(s): 1. _____ 3. _____
  2. _____ 4. _____
- ☐ Medication must be given and/or available at school

☐ **Allergy**
- ☐ Food: _____ ☐ Insect: _____ ☐ Medicine: _____ ☐ Other: _____
- Type of allergic reaction: ☐ Anaphylaxis ☐ Local reaction
- Response required: ☐ Epinephrine Auto-injector ☐ Other: _____ ☐ None

☐ **Developmental Concerns Identified** (See comments below)
Child needs referral to school support team for further evaluation.

☐ **Special Diet**
Guidance: _____

☐ **Health-Related Recommendations to Enhance School Performance**
For example: sitting near the front of classroom, special equipment needs.
Please specify: _____

☐ **School Health Forms Attached**
- ☐ School Medication Authorization Form ☐ Diabetes Care Plan ☐ Asthma Action Plan
- ☐ Health Care Plan(s) List Condition _____

Comments: _____

Was this assessment completed in the child's regular health care provider's office? ☐ ***yes*** ☐ ***no***
If no, please provide a copy to the child's parent to give to the child's regular health care provider.

Health Care Professional's Certification - Attach a copy of the immunization record.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: _____ Provider Stamp Here

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____

Personal Data

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PARENT COMPLETE

Child's Birthdate: ____ /____ 20 ____ (mm/dd/yyyy)

Sex: ☐ 1 Male ☐ 2 Female

County of Residence: _____

Zip Code: _____

School your child will be attending: _____

Place where your child gets regular health care:

☐ 1 Health Department
☐ 2 Hospital Clinic
☐ 3 Community Health Center
☐ 4 Private Doctor/HMO
☐ 5 Other _____
☐ 6 No regular place

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Hispanic or Latino Origin: ☐ 1 Yes ☐ 2 No

Child has:
☐ 1 Medicaid ☐ 2 Private Insurance/HMO ☐ 3 No Insurance ☐ 4 Other: _____

Doctor/Practice Name: _____

Dentist Name: _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: ____/____/____

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Immunizations - Attach a copy of the immunization record.

Pertinent Illnesses, Risks or Developmental Problems: *(Please check all that apply)*

☐ Allergy
☐ Anemia ☐ At-Risk for Anemia
☐ Asthma
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorders
☐ Lead (Hx of ≥10 mcg/dL) ☐ At-Risk ☐ Test done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other: _____
☐ None

Screening Results

Developmental

Screening Tool(s) Used:
☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern Identified 2	Referred to Specialist 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Comments: _____

Hearing

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.

Screening Tool Used:
☐ 1 OAE
☐ 2 Audiometry

☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.
☐ 3 Referral to audiologist/ENT (check if yes)
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	Right	Left	Stereopsis ☐ Pass ☐ Fail
Far:	20/	20/	Acuity Test Used:
Was test performed with corrective lenses? ☐ ***yes*** ☐ ***no***			

☐ 1 Pass (Acuity, Stereopsis, & Symptoms)
☐ 2 Referral to eye doctor (check if YES) Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease.
☐ 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.

Physical Examination

Weight: _____ lbs. Height: ___ ft. ____ in.

Body Mass Index (BMI) - for age: _____
☐ 1 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to < 85%ile)
☐ 3 Overweight (85%ile to < 95%ile)
☐ 4 Obese (≥ 95%ile)

Blood Pressure: _____ / _____
☐ 1 Within Normal Range
☐ 2 > 90th Percentile (_____ %ile)

	Normal 1	Abnormal 2
HEENT	☐	☐
Dental/Oral	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurological	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

Comments: _____

-Back-