

# BETHEL BAPTIST SCHOOL

## Application for Enrollment – International Student

Please print clearly using black or blue ink.

Today's Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

Circle the grade for which student is applying:

1 2 3 4 5 6 7 8 9 10 11 12

### Student Information

Name **exactly** as it appears on passport \_\_\_\_\_ English Name (if any) \_\_\_\_\_ SEVIS ID# (if any) \_\_\_\_\_

Country of Birth \_\_\_\_\_ Country of Citizenship \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender (M / F) \_\_\_\_\_

Complete Address in Home Country \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_

U.S. Address (if any): Number & Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

School Last Attended \_\_\_\_\_ Grade Average \_\_\_\_\_ List Allergies and/or Prescription Medications Taken by Student \_\_\_\_\_

How many years will your child study at Bethel Baptist School? \_\_\_\_\_

Has your child ever been promoted more than one grade in a year? Yes No If yes, when? \_\_\_\_\_

Has the student ever repeated a grade? Yes No If yes, what grade? \_\_\_\_\_

Has the student recently had any serious illness? Yes No If yes, what illness? \_\_\_\_\_

### Family Information

Father's Last Name \_\_\_\_\_ Father's First Names \_\_\_\_\_ Email Address (required) \_\_\_\_\_

Father's Employer \_\_\_\_\_ Work Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home or Cell Phone (please circle one) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mother's Last Name \_\_\_\_\_ Mother's First Names \_\_\_\_\_ Email Address (required) \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Work Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home or Cell Phone (please circle one) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Names and ages of brothers and sisters:

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

What church or religious group does the student attend (if any)? \_\_\_\_\_

Do you understand that Bethel Baptist School is a Christian School and agree that your child will attend religion classes and learn the Bible, its history, and the teachings of Jesus Christ? Yes No

Do you agree to authorize this school to use discipline that it considers wise and necessary for the welfare of your child – especially in the areas of behavior and dress code? Yes No

Are you currently, or do you intend to apply for a Permanent Residence Card (Green Card)? Yes No

Father's Signature \_\_\_\_\_ Date \_\_\_\_\_

Mother's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medical History (Fill in the circles [●] for all that apply.)**

It is *mandatory* that pupils who show symptoms of a communicable disease or illness be excluded from classes until cleared by a doctor and approved by school administration.

Father's Health:    Excellent     Average     Poor

If poor, please explain: \_\_\_\_\_

Mother's Health:    Excellent     Average     Poor

If poor, please explain: \_\_\_\_\_

If either parent(s) are deceased, state cause: \_\_\_\_\_

**Past Diseases**            (Please mark any of the following diseases that your child has had.)

- Chicken Pox        Mumps            Rheumatic Fever
- Diphtheria        Pneumonia     Scarlet Fever
- Measles            Polio             Whooping Cough

Other (explain): \_\_\_\_\_

**Recent Illness or Disability**    (Please mark any of the following that your child has experienced.)

- |                             |                       |                      |                       |                        |                       |
|-----------------------------|-----------------------|----------------------|-----------------------|------------------------|-----------------------|
| Abdominal Pains             | <input type="radio"/> | Dizziness            | <input type="radio"/> | Persistent Cough       | <input type="radio"/> |
| Allergies                   | <input type="radio"/> | Fainting Spells      | <input type="radio"/> | Pink Eye               | <input type="radio"/> |
| Asthma                      | <input type="radio"/> | Growing Pains        | <input type="radio"/> | Poor Vision            | <input type="radio"/> |
| Breath Shortness            | <input type="radio"/> | Hay Fever            | <input type="radio"/> | Ringworm               | <input type="radio"/> |
| Colds (Four or More Yearly) | <input type="radio"/> | Hearing Difficulty   | <input type="radio"/> | Sore Throat (Frequent) | <input type="radio"/> |
| Convulsions                 | <input type="radio"/> | Heart Disease        | <input type="radio"/> | Speech Difficulty      | <input type="radio"/> |
| Crippling Conditions        | <input type="radio"/> | Hernia (Rupture)     | <input type="radio"/> | Sties (Frequent)       | <input type="radio"/> |
| Dental Defects              | <input type="radio"/> | Impetigo             | <input type="radio"/> | Tires Easily           | <input type="radio"/> |
| Diabetes                    | <input type="radio"/> | Leg Pains (Frequent) | <input type="radio"/> | Urination (Frequent)   | <input type="radio"/> |
| Discharging Ears            | <input type="radio"/> | Nose Bleed           | <input type="radio"/> |                        |                       |

Other (explain): \_\_\_\_\_

**Immunization**            (Please mark any of the following for which your child has been immunized.)

- |             |                       |             |                       |                 |                       |                |                       |
|-------------|-----------------------|-------------|-----------------------|-----------------|-----------------------|----------------|-----------------------|
| Chicken Pox | <input type="radio"/> | Hepatitis B | <input type="radio"/> | Schick Negative | <input type="radio"/> | Tetanus        | <input type="radio"/> |
| COVID-19    | <input type="radio"/> | Measles     | <input type="radio"/> | Smallpox - Scar | <input type="radio"/> | Typhoid        | <input type="radio"/> |
| Diphtheria  | <input type="radio"/> | Polio       | <input type="radio"/> | Tdap Booster    | <input type="radio"/> | Whooping Cough | <input type="radio"/> |

Other (explain): \_\_\_\_\_

**Personal Record**    (Please mark any of the following that pertain to your child.)

- |                   |                       |                        |                       |               |                       |                              |
|-------------------|-----------------------|------------------------|-----------------------|---------------|-----------------------|------------------------------|
| Angers easily     | <input type="radio"/> | Excessive Fears        | <input type="radio"/> | Overly Active | <input type="radio"/> | Other (Please explain below) |
| Bites Fingernails | <input type="radio"/> | Gets along with Others | <input type="radio"/> | Shy           | <input type="radio"/> | _____                        |
| Eats Breakfast    | <input type="radio"/> | Likes School           | <input type="radio"/> |               |                       | _____                        |

What is the student's regular bedtime? \_\_\_\_:\_\_\_\_ p.m.    rising time? \_\_\_\_:\_\_\_\_ a.m.

Does your child have any disability due to disease or accident?    Yes    No

Explain: \_\_\_\_\_

Has your child had a skin test for tuberculosis?    Yes    No    When? \_\_\_\_\_

Has he been associated with a tubercular patient?    Yes    No    When? \_\_\_\_\_