

# Application of Admission

*Excelsior Elementary School*

Phone: 341-4503 or 341-0397  
Carmichael Road & Prince Charles Drive  
P.O. CB-13283

\_\_\_\_\_ 20\_\_\_\_\_  
DATE OF ENTRY

(PLEASE A COPY ATTACH IMMUNIZATION CARD, PHOTO, BIRTH CERTIFICATE, NIB CARD, & PASSPORT)

## A. CHILD'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	MALE OR FEMALE GENDER
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D.O.B	MM/DD/YYYY	AGE	PLACE OF BIRTH	NATIONALITY
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Email address \_\_\_\_\_

### HOME ADDRESS

Full Address (Street Name, House Number & Color)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

P.O. Box

## B. SCHOOL HISTORY

(Only if child has not attended any Pre-School or Daycare prior to Little Feet Academy or Excelsior)

Has your child attended L.F.A (Faith, Prince Charles, St. Michaels or Carmichael) before?

YES or NO

1. \_\_\_\_\_  
School Name                      Grade Level                      Year                      Location
2. \_\_\_\_\_  
School Name                      Grade Level                      Year                      Location
3. \_\_\_\_\_  
School Name                      Grade Level                      Year                      Location

**C. FAMILY INFORMATION**  
**MOTHER OR FEMALE GUARDIAN**

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Name	Nationality	Place of Birth		
Street Address	P.O. Box	Home Number	Work Number	Cell Phone
_____ @ _____		Marital Status: Single Married		
Place of Employment	Email Address	Divorce	Widowed	
_____		<b>who is Responsible for Billing? Mom Dad</b>		
Religious Affiliations	Church	<b>Other:</b> _____		

**FATHER OR MALE GUARDIAN**

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Name	Nationality	Place of Birth		
Street Address	P.O. Box	Home Number	Work Number	Cell Phone
_____ @ _____		Marital Status: Single Married		
Place of Employment	Email Address	Divorce	Widowed	
_____				
Religious Affiliations	Church			

**IN CASE OF EMERGENCY AND PARENTS CANNOT BE CONTACTED WHO SHOULD WE CONTACT?**

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Name	Phone Number(s)	Relation to Child
_____	_____	_____
Name	Phone Number(s)	Relation to Child
_____	_____	_____
Name	Phone Number(s)	Relation to Child
_____	_____	_____
Name	Phone Number(s)	Relation to Child
_____	_____	_____

**LIST NAMES AND NUMBERS OF PERSONS AUTHORIZED TO COLLECT CHILD**

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Name	Phone Number(s)	Relation to Child
_____	_____	_____
Name	Phone Number(s)	Relation to Child
_____	_____	_____
Name	Phone Number(s)	Relation to Child
_____	_____	_____
Name	Phone Number(s)	Relation to Child
_____	_____	_____

**NAMES OF SIBLINGS**

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Name	Phone Number(s)	Relation to Child
_____	_____	_____

Name

Phone Number(s)

Relation to Child

**D. Health Information**

**Name of Clinic**

**Doctors Name**

**Doctor's Numbers**

**Does the child have Health or Accidental Insurance? YES or NO**

**INSURANCE COMPANY**

**POLICY HOLDER NAME**

**POLICY HOLDER PLACE OF EMPLOYMENT**

**INSURANCE ID NUMBER**

**GROUP NUMBER**

**Can the child participate in Physical Education? YES or NO**

**In case hospitalization is necessary please indicate which hospital you wish for your child to be taken to?**

Princess Margaret Hospital

Doctors Hospital

Other: \_\_\_\_\_

**Please circle any of the following conditions your child may suffer from:**

Allergies      Asthma      Congenital      Abnormalities      Convulsions/Epilepsy

Frequent Headaches/Migraines      Fainting      Hearing Difficulties      Heart Problem

High/Low Blood Pressure      HIV      Kidney/Urinary Infections      Orthopedic Problems

**Please Explain:**

**Does your child wear spectacles (glasses)? Yes or No**

**Is this child under special medication? Yes or No**

**Does this child routinely take medication? Yes or No**

**Any known allergies to medication? Yes or No**

**If yes to any of the above, please explain: \_\_\_\_\_**

**Please list (in detail) any know emotional problems with child: \_\_\_\_\_**

**Please list any surgical operations and approximate dates: \_\_\_\_\_**

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## Parent/Guardian Agreement Form

**Please read document carefully, sign and return to Excelsior Elementary School**

1. I understand that it is my responsibility to read the parent hand book, newsletters and other communications produced by **Excelsior Elementary School** to keep informed of schools policy, general school information and other necessary information.
2. I understand that I am expected to meet my financial obligations term payment on the following dates AUGUST 27, NOVEMBER 27, and FEBRUARY 27.
3. I understand that the school fees must be paid by credit card or at the bank assigned. Cash will not be accepted for *tuition* at the business office. In this regard, I understand that \$50.00 late payment fees will be charged for any late payment. Should a cheque be returned there will be a return cheque fee of \$50.16
4. I understand that is my responsibility to inform the school of any occasion when it is necessary to take my child off campus during school hours. In such cases parent/guardian are expected to sign out their child from the office.
5. It is my responsibility to see that my child attends school regularly, on time and fully clad in school's uniform, unless prior permission was given by the administrator.
6. I understand that my child can only advance to the next level upon completion and able to master the grade level he/she may be in at present.
7. I understand that it is my responsibility to partner with my child's teacher by periodically checking on the progress of my child.
8. I give my child permission to accompany the class or the school on related field trips, which takes place during school hours.
9. I understand that it is my responsibility to have my child adequately covered with medical insurance.
10. I understand that in the event of minor complaints or accidents the school office will treat my child. However, in the event of a serious illness or accident, I will be contacted and ask to collect my child. In cases of emergency, Excelsior Elementary School reserves the right to call an ambulance.
11. I understand that I will follow the schools Problem solving policy/protocol as outlines in the Parent hand book.
12. I understand that Excelsior Elementary School, reserve the rights to dismiss any student whose parents display dissatisfaction or non cooperation with the school in matters pertaining to my child's education.
13. I pledge my full support to the school and promise to attend if not all, most of the Parents Teachers Meetings that the school will have and be an active member/participant on the school PTA Board.
14. In accepting a place at Excelsior Elementary school, I hereby consent to and agree with the rules set out in the Parent/student hand book and agree to cooperate fully with the school in all matters pertaining to my child's education.

### **CHARACTER COUNTS**

Excelsior Elementary school's Character Education Program is called Character Counts. This program is centered on the Common vocabulary of six pillars of character: Trustworthiness, Respect, Responsibility, Fairness, Caring, and Citizenship. These pillars will be part of daily classroom instruction and the school discipline policies. Students are recognized throughout the school year for actions that exemplify the six pillars.

### **DISCIPLINE POLICY**

The purpose of the EES's discipline policy, is to guide children to be people of character. We strive to improve student behavior rather than punish children for misbehavior. Teachers manage discipline problems in class, but inform families and the Principal when a child repeatedly fails to follow the school rules and instructions.

**FIGHTING/STEALING/SWEARING**

Students that have challenges such as fighting, stealing and swearing, parents will be called in and disciplinary actions will be taken. In the event that there is no change in the child's behavior, that child will be expelled from New Providence Center.

**AGREEMENT**

PLEASE READ CAREFULLY

I AGREE TO SUPPORT THE OBJECTIVES, RULES, REGULATIONS, AND POLICIES OF EXCELSIOR ELEMENTARY SCHOOL AND TO ATTEND SCHEDULED P.T.A. MEETINGS, OPEN HOUSE MEETINGS, AND OTHER NECESSARY FUNCTIONS PERTAINING TO THE EDUCATION OF MY CHILD.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL TUITION FEES IN ADVANCE AS SET FORTH BY EXCELSIOR ELEMENTARY SCHOOL. FURTHERMORE, I UNDERSTAND THAT ALL TUTION AND REGISTRATION/SEAT FEES ARE NON- REFUNDABLE AND NON- TRANSFERABLE.

I GIVE PERMISSION FOR MY CHILD TO TAKE PART IN ALL SCHOOL ACTIVITIES, INCLUDING FIELD TRIPS AWAY FROM THE SCHOOL PREMISES. I ALSO UNDERSTAND THAT MINOR INJURIES CAN AND MAY HAPPEN TO MY CHILD WHILE IN YOUR CARE (E.g. SCRATCHES, BUMPS AND SIMPLE FALLS) IN ADDITION, I THEREFORE ABSOLVE Excelsior Elementary School FROM ANY LIABILITIES TO ME OR MY CHILD BECAUSE OF THESE SIMPLE INJURIES).

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PARENT'S FULL NAME (PRINT)

SIGNATURE

DATE

WITNESS

# Child Health Assessment

CHILD'S NAME ( LAST)	(FIRST)	PARENT/GUARDIAN	PHONE
DATE OF BIRTH	HOME NUMBER	PARENT/GUARDIAN	PHONE
CHILD CARE FACILITY NAME		PLACE OF EMPLOYMENT	PHONE
DOCTORS NAME	PHONE NUMBER(S)	ADDRESS	EMAIL

*To Parents, Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's school.*  
 Child Care providers must document that enrolled children have received age appropriate health services and immunization.

<b>Health history and medical information pertinent to routine child care and emergencies (describe, if any)</b>	<b>Date of most recent well-child exam:</b>
<b>Allergies to food or medicine (describe, if any)</b>	

LENGTH/ HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE & TYPE				
_____ Feet/Inches	_____ Lbs	_____ Inches	_____ & _____				
<b>PHYSICAL EXAMINATION</b>	<b>X = NORMAL</b>	<b>IF ABNORMAL - COMMENTS</b>					
Head/Ears/Eyes/Nose/Throat							
Teeth							
Cardio respiratory							
Abdomen							
Rectal							
Extremities/joints/back/chest							
Hair/Scalp/Skin/Lymp Node							
Neurologic & Developmental							
<b>IMMUNIZATION</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>COMMENTS</b>
D.P.T Hib							
Hep. B							
Booster							
Polio							
Booster							
MMR							
MMR							
Rubella							
<b>SCREENING TEST</b>	<b>DATE TEST DONE</b>						
Anemia							
Urinalysis							
Hearing							
Vision							
ProceSSIONal Dental Exam							
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach Additional Sheets If Necessary)							
Signature of Doctor				Stamp of Doctor/Clinic & Date			