

Recommendation Information Sheet



1st Grade – 12th Grade

Please provide a name and email address for a current principal/school administrator, current teacher, and a minister or character reference. Submit completed sheet to the Admissions Office so your references can be contacted.

Principal/Administrator _____

Email _____

Teacher _____

Email _____

Minister/Character _____

Email _____

My child is applying to attend Brentwood Christian School. As part of the admissions process, the school requires a recommendation from a current principal, teacher, and minister/character reference.

Brentwood Christian School has my permission to send current school administrators / faculty and the character reference the link to complete the recommendation.

_____ has my permission to release my child's
(School name)
information electronically pertaining to the recommendation request.

Parent Signature

Date

Student Name

Grade



Learning with a Higher Purpose

Dear Registrar,

Please consider this a confirmation of application for enrollment to Brentwood Christian School for one of your students. Please find attached the *Request for Records Form* requesting copies of the transcripts for a minimum of the last two completed school years including anything year to date for this school year, achievement test results if applicable for the previous two years, any disciplinary records, and a birth certificate. Please let me know if you have any questions.

Thank you in advance for your help in forwarding this documentation to me.

A handwritten signature in cursive script that reads 'Kimberly McFain'.

Director of Admissions
Brentwood Christian School
admissions@brentwoodchristian.org
Office (512) 835-5983 x118
Fax (512) 835-2184



Brentwood Christian School
11908 N. Lamar Boulevard
Austin, TX 78753
512-835-5983
Fax: 512-835-2184

REQUEST FOR RECORDS:

Date: _____

School: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School Phone: _____ School Fax: _____

Name of Student: _____ Birth Date: _____

This student is applying for _____ grade at Brentwood Christian School for the
school year _____.

Please send the following information:

- Transcripts of school records for last completed 2 to 3 years if applicable (including current year to date if partial year)
- Disciplinary records
- Immunization records
- Birth certificate
- All achievement test scores

Please return these records to me as soon as possible.

Brentwood Christian School Director of Admissions

Parent's Name: _____

Parent's Signature: _____



HEALTH EXAMINATION FORM

Brentwood Christian School

To Be Completed by the Doctor

NAME _____ DATE OF BIRTH _____ HT. _____ WT. _____

VACCINES	*Date	*Date	*Date	*Date	*Date	*Date
DTP/DTaP/DT/Td						
OPV, IPV**						
Measles						
Mumps and Rubella						
Hib(pre-K4 only)						
PCV (pre-K4 only)						
Varicella						
Hepatitis A						
Hepatitis B						
Meningococcal						
TB Test and Result (need for TB test to be determined by physician)						

* month/date/year

** circle one

Comment in regard to these factors of child's **GENERAL HEALTH**:

1) Has this child: (Please explain any yes answers)

- | | | | |
|---|------------|-----------|--|
| a) had any chronic illnesses – i.e., Asthma, Diabetes, Cystic Fibrosis? | Yes: _____ | No: _____ | |
| b) had any allergies that require special attention or medication? | Yes: _____ | No: _____ | |
| c) had any past history of head injury, concussion, seizure, etc.? | Yes: _____ | No: _____ | |
| d) had any heart or blood pressure abnormalities? | Yes: _____ | No: _____ | |
| e) had any spinal injuries or spinal defects of any kind? | Yes: _____ | No: _____ | |
| f) had any need for medication at school? | Yes: _____ | No: _____ | |
| g) been exposed to tuberculosis? | Yes: _____ | No: _____ | |
| h) been subject to headaches? | Yes: _____ | No: _____ | |
| i) had any serious or significant accidents (give dates)? | Yes: _____ | No: _____ | |
| j) had any surgical procedures (give dates)? | Yes: _____ | No: _____ | |
| k) been prescribed corrective lenses (if so, date of last eye exam)? | Yes: _____ | No: _____ | |
| l) had any serious or significant dental needs? | Yes: _____ | No: _____ | |
| m) had the chicken pox (give date)? | Yes: _____ | No: _____ | |

2) List any limitations for this child's participation in physical education, sports or school activities. _____

Vision Screening	
Distance Acuity	R _____ L _____
Muscle Balance:	Pass Fail
Corrective Lens:	Yes No
<input type="checkbox"/> Pass	
<input type="checkbox"/> Referred for evaluation	
Signature _____	Date _____

Hearing Screening		
25 dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		
<input type="checkbox"/> Pass		
<input type="checkbox"/> Referred for evaluation		
Signature _____	Date _____	

Scoliosis Screening	
<input type="checkbox"/>	Normal
<input type="checkbox"/>	Referred for evaluation
<input type="checkbox"/>	Under doctor's care for Scoliosis
Signature _____	Date _____

Teeth _____
 Nose and Throat _____
 Skin _____
 Hair _____
 Thyroid _____
 Heart _____
 Lungs _____
 Orthopedic/Spine _____
 Emotional or nervous _____
 Nutrition _____
 Remarks _____

Date _____

Physician's Signature _____

Printed Name _____



**HEALTH HISTORY/INSTRUCTIONS FOR HEALTH NEEDS
Brentwood Christian School**

This form is to be completed by parents or guardians of any student applying to Brentwood Christian School who has a chronic or potentially serious health condition or any student currently enrolled who develops such a condition. Acceptance or continuance of students is condition upon full disclosure of information regarding health concerns and agreement to the terms of this statement.

Student's name _____

Applying for (or enrolled in) grade _____ for school year _____

Please state the exact nature and history of any chronic or potentially serious health condition:

Current written directives from a physician for medication or treatment:

Description of the initial triggering event and any subsequent common triggers:

Expectation of school personnel consistent with the school's Protocol for Students with Chronic or Severe Health Concerns:

The signature(s) of parents or guardians below verify that I/we have read the Protocol for Students with Chronic or Severe Health Concerns, and that I/we understand that the school is not a medical facility, is not accepting responsibility for the student's health care, and cannot provide medical treatment or any support or assistance beyond that specifically agreed upon prior to acceptance.

Parent or Guardian Signature

Date

Parent or Guardian Signature

Date

School Representative

Date

Student Name _____
Date of Birth _____

MEDICATION PERMISSION FORM

Brentwood Christian School will not administer any prescription or non-prescription medication without parental permission. If you want your child to receive a non-prescription medication, **the parent must send the medication in its original container along with a permission note.** The note must include name of medication, reason for giving medication, and amount and time to be given. Directions on over-the-counter packaging regarding age, dose and frequency will be adhered to. For prescription medication, parents must send the medicine in the original pharmacy prescription bottle with a permission note. Please fill out the form below if you would like to keep a permission form on file for your child.

Medication _____
Reason for giving medication _____
Amount to be given (dosage) _____ Time to be given _____
Date medication to be discontinued _____

Medication _____
Reason for giving medication _____
Amount to be given (dosage) _____ Time to be given _____
Date medication to be discontinued _____

Medication _____
Reason for giving medication _____
Amount to be given (dosage) _____ Time to be given _____
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Amount to be given (dosage) _____ Time to be given _____
Date medication to be discontinued _____

Medication _____
Reason for giving medication _____
Amount to be given (dosage) _____ Time to be given _____
Date medication to be discontinued _____

This permission form is in effect and valid for as long as my child is enrolled at Brentwood Christian School.

Parent Signature _____ Date _____



PROTOCOL: Students with Chronic or Severe Health Concerns

Brentwood Christian School provides Christian education for students who are able to receive instructions in a mainstream classroom setting. The school is not able to provide special resources for students with severe physical handicaps, medical needs, or educational disabilities. The following policies apply to the acceptance and continuance of students with chronic and severe health conditions at Brentwood Christian School:

1. **Admission.** We will admit students to the school only when we are assured that their health, safety, and well being—and that of our other students and staff—can be maintained without unusual medical procedures or undue disruption to learning opportunities and the normal school day.
2. **Continuance.** Students who are diagnosed with a chronic or severe health condition after having been accepted to the school will be able to continue as students under the same conditions stated in regard to admission above.
3. **Self-management.** Brentwood Christian School does not accept responsibility for the student's health care. Students with chronic conditions (e.g., allergies, asthma, diabetes) must be responsible and self-managing, so that the role of the school is to double-check and follow up according to prior agreement rather than to check and administer treatment.
4. **Health History/Instruction Form.** Parents of students with any chronic condition must complete a health history/instruction form prepared by the school, providing this information:
 - a. The exact nature and history of the student's condition
 - b. Any written directives from a physician for medication or treatment
 - c. Descriptions of the initial triggering event and any subsequent common triggers
 - d. Expectations of school personnel consistent with this protocolParents' signature on this form indicates their understanding that the school is not a medical facility, is not accepting responsibility for the student's health care, and cannot provide medical treatment or any support or assistance beyond that specifically prescribed on this form.
5. **Privacy and disclosure.** Teachers of classes with students who have chronic health concerns will gain consent from parents for minimal disclosure of information about the students' condition. When needed and with the parents' consent, they will provide to their classes gentle general explanations of normal precautions to take regarding these students' health and signs to watch for in case of a problem. This will be done with care not to alarm other students unduly.
6. **Administration of medication.** Parents of students who must take prescription medication during the school day must bring their medication to school in the original container, properly labeled with the name of the student, the prescribing physician, the medication, and the dosage. The medication may be kept in the office or in the classroom in a locked drawer. The staff member or teacher who provides the medication to the student must record each dose on a log sheet. Medication that is given longer than two weeks requires a signed physician's order.
7. **Use of inhalers.** Students requiring inhalers may carry their inhalers with them throughout the day if the parent and physician agree that they should. If the inhaler is found outside the student's possession or is given to another student, it will thereafter be kept in the office. Parents will sign a contract regarding this agreement.
8. **Use of epipens.** Students with risk of anaphylactic shock may have epipens kept in the school office. Only with a written directive from a physician may they keep an epipen with them. In such cases, it may be kept in a carrying bag under the same conditions stated in regard to inhalers above.

STUDENT'S NAME (PRINT): _____ SPORT(S): _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

PREPARTICIPATION PHYSICAL EVALUATION MEDICAL HISTORY

The 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.

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, physician's assistant, chiropractor, or nurse practitioner is required before any participation in TAPPS practices, games or matches.

- 9. Have you had a medical illness or injury since your last checkup or sports physical? YES NO
 - 10. Have you been hospitalized overnight in the past year? YES NO
 - 11. Have you ever had surgery? YES NO
 - 12. Have you ever passed out during or after exercise? YES NO
 - 13. Have you ever had chest pain during or after exercise? YES NO
 - 14. Do you get tired more quickly than your friends during exercise? YES NO
 - 15. Have you ever experienced racing of your heart or skipped heartbeats? YES NO
 - 16. Have you ever had high blood pressure? YES NO
 - 17. Have you ever had high cholesterol? YES NO
 - 18. Have you ever been told you have a heart murmur? YES NO
 - 19. Has any family member or relative died of heart problems before age 50? YES NO
 - 20. Has any family member or relative died of sudden unexpected death before age 50? YES NO
 - 21. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)? YES NO
 - 22. Has any family member been diagnosed with Hypertonic Cardiomyopathy? YES NO
 - 23. Has any family member been diagnosed with Long QT Syndrome? YES NO
 - 24. Has any family member been diagnosed with ion channelopathy (Brugada syndrome, etc.)? YES NO
 - 25. Has any family member been diagnosed with Marfan's syndrome? YES NO
 - 26. Have you had a severe viral infections (myocarditis, mononucleosis, etc.) in the past year? YES NO
 - 27. Has a physician ever denied or restricted your participation in sports for any heart problem? YES NO
 - 28. Have you ever had a head injury or concussion? YES NO
 - 29. Have you ever had been knocked out, become unconscious or lost your memory? YES NO
 - 30. Have you ever experienced a seizure? YES NO
 - 31. Have you ever had numbness in your arms, hands, legs or feet? YES NO
 - 32. Have you ever had a stinger, burner or pinched nerve? YES NO
 - 33. Are you missing any paired organs? YES NO
 - 34. Are you presently under a doctor's care? YES NO
 - 35. Are you currently taking any prescription or nonprescription medications or inhalers? YES NO
 - 36. Do you have any allergies? YES NO
 - 37. Have you ever been dizzy before or during exercise? YES NO
 - 38. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)? YES NO
 - 39. Have you ever become ill after exercising or working in the heat? YES NO
 - 40. Have you ever had any problems with your eyes or vision? YES NO
 - 41. Have you ever gotten unexpectedly short of breath with exercise? YES NO
 - 42. Do you have asthma? YES NO
 - 43. Do you have seasonal allergies that require medical treatment? YES NO
 - 44. Do you use any special protective or corrective equipment? YES NO
 - 45. Have you ever had a sprain, strain, or swelling after injury? YES NO
 - 46. Have you ever broken or fractured any bones? YES NO
 - 47. Have you ever dislocated any joints? YES NO
 - 48. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints? YES NO
- If yes, please check the appropriate box and explain on separate sheet of paper.
- Head Neck Back Chest Shoulder Upper Arm Elbow Forearm
 Wrist Hand Finger Hip Thigh Knee Foot Ankle Shin/Calf
- 41. Do you want to weigh more or less than you do now? YES NO
 - 6. Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities? YES NO
 - 7. Do you feel stressed out? YES NO
 - 8. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease? YES NO

Females Only

- 1. When was your first menstrual period? _____
- 2. When was your most recent menstrual period? _____
- 3. How much time elapses from the start of one period to the start of another? _____ days
- 4. How many periods have you had in the last year? _____
- 5. 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 judgement 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

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: _____

HEIGHT: _____ WEIGHT: _____ % OF BODY FAT: _____

PULSE: _____ BLOOD PRESSURE: _____ / _____ (_____ / _____)

VISION R 20/ _____ L 20/ _____ CORRECTED: Y N Pupils: EQUAL _____ UNEQUAL _____

In keeping with the requirements of the Texas Association of Private and Parochial School as a minimum requirement, this PHYSICIAN EXAMINATION FORM must be completed prior to high school athletic participation each year of high school.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart - Auscultation of the heart in the supine position			
Heart - Auscultation of the heart in the standing position			
Heart - Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE (TO BE COMPLETED BY PROVIDER)

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Provider Name: _____ Date of Examination: _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

This Medical History Form reviewed by: NAME: _____ DATE: _____ *For school use only:*

CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way a student's brain normally functions
- Can occur during practice or contests in any sport
- Can occur in activities both associated and not associated with the school
- Can occur even if the student has not lost consciousness
- Can be serious even if a student has just been "dinged" or had their "bell rung"

Are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, one or more of the following symptoms may become apparent. The student may not "feel right" soon after, a few days after or even weeks after the injury event.

Headache	"Pressure" in the head	Nausea	Vomiting
Balance problems	Dizziness	Blurry Vision	Double Vision
Sensitivity to Light	Sensitivity to Noise	Confusion	Memory Problems
Difficulty paying attention	Feeling sluggish, hazy, foggy or groggy		

If you have concerns regarding any of the above symptoms, your doctor should be consulted for further information and/or examination. Your physician or medical professional can best determine your student's physical condition and ability to participate in athletics.

What should students do if they believe that they or someone else may have a concussion?

- Students should immediately notify their coach or school personnel.
- Student should be examined by appropriate medical personnel of the parent's choosing. The medical provider should be trained in the diagnosis and treatment of concussions
- If no concussion is diagnosed, the student shall be cleared to return to athletic participation.
- If a concussion is diagnosed, the school protocol for return to play from a concussion shall be enacted. Under no circumstances shall the student be allowed to return to practice or play without the approval of a licensed medical provider trained in the treatment of concussions.

I have reviewed the above material. I understand the symptoms and warning signs of CONCUSSIONS. Additional information is available on the Health and Safety page at www.tapps.biz. All concussions should be reported to the school as soon as possible. Previous concussions should be reported on the Medical History form to allow the medical practitioner the best information possible when conducting the annual physical examination.

Parent Signature / Date: _____

Student Signature / Date: _____

CONCUSSIONS – Don't hide it. Report it. Take time to recover.

SUDDEN CARDIAC ARREST

What is Sudden Cardiac Arrest (SCA)?

Sudden Cardiac Arrest is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is not a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction of the heart's electrical system, causing the heart to stop beating.

How common is Sudden Cardiac Arrest?

While studies differ in the actual rate of occurrence, the American Heart Association information indicates that there are approximately 300,000 SCA events outside hospitals each year in the United States. About 2000 patients under the age of 25 die of SCA each year. Studies now being performed in Texas and other states indicate the occurrence rate for high school age athletes may be greater than this figure.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

Dizziness	Fatigue	Lightheadedness
Extreme tiredness	Shortness of breath	Nausea
Difficulty breathing	Vomiting	Racing or fluttering heartbeat
Chest Pains	Syncope (fainting)	

These symptoms can be confusing and unclear in athletes. Often people confuse these warning signs as physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

For this reason these symptoms are included on the Medical History form provided by TAPPS and required for each student prior to participation in athletic events each year. As parents and student athletes, your truthful answers to these simple questions will assist your medical practitioner when performing the annual physical examination.

What are the risks of participation and playing with these symptoms?

Continued participation brings with it increased risk. This includes playing in practices and games. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just minutes. Most people who experience a SCA die from the event.

While TAPPS does not mandate Cardiac Screening prior to participation, TAPPS and the TAPPS member schools recognize the importance of our students' health and highly recommend discussing screening options with your healthcare provider. Any student who shows signs of SCA should be removed by the parents from play. This includes all athletic activity, practices or contests. Before returning to play, the student should be examined and receive clearance by a licensed health care professional of the parents' choosing.

**I have reviewed the above material. I understand the symptoms and warning signs of SCA.
Additional information is available on the Health and Safety page at www.tapps.biz.**

Parent Signature / Date: _____

Student Signature / Date: _____



Brentwood Christian School

STUDENT APPLICANT QUESTIONNAIRE

The student must complete this section of the application in his or her own handwriting.

What are your special interests and hobbies?

Which studies interest you most?

List any extracurricular activities in which you have participated: (Also list any awards or offices.)

School: _____

Church: _____

Community: _____

Do you plan to attend college after graduation? _____

Describe your plans briefly:

Please write in your own words the answer to the following question:

Do you wish to attend Brentwood Christian School? _____

Why? _____

Student Signature