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.

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)
- ❑ Copy of IEP or 504 Plan
- ❑ Disciplinary records
- ❑ Immunization records
- ❑ Birth certificate
- ❑ All achievement test scores

Please return these records to me as soon as possible.

Kimberly McCain

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:_____ _____
j) been prescribed corrective lenses (if so, date of last eye exam)? Yes:_____ No:_____ _____
k) had any serious or significant dental needs? Yes:_____ No:_____ _____
l) 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

☐ Pass
☐ Referred for evaluation

Signature Date

Hearing Screening

25 dB	R	L
500 Hz		
1000 Hz		
2000 Hz		
4000 Hz		

☐ Pass
☐ Referred for evaluation

Signature Date

Scoliosis Screening

☐ Normal
☐ Referred for evaluation
☐ 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 _____
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 _____
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 protocol

    Parents' 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, physicians assistant, chiropractor, or nurse practitioner is required before any participation in **TAPPS** practices, games or matches.

	YES	NO
9. Have you had a medical illness or injury since your last checkup or sports physical?	☐	☐
10. Have you been hospitalized overnight in the past year?	☐	☐
11. Have you ever had surgery?	☐	☐
12. Have you ever passed out during or after exercise?	☐	☐
13. Have you ever had chest pain during or after exercise?	☐	☐
14. Do you get tired more quickly than your friends during exercise?	☐	☐
15. Have you ever experienced racing of your heart or skipped heartbeats?	☐	☐
16. Have you ever had high blood pressure?	☐	☐
17. Have you ever had high cholesterol?	☐	☐
18. Have you ever been told you have a heart murmur?	☐	☐
19. Has any family member or relative died of heart problems before age 50?	☐	☐
20. Has any family member or relative died of sudden unexpected death before age 50?	☐	☐
21. Has any family member been diagnosed with enlarged heart (Dilated Cardiomyopathy)?	☐	☐
22. Has any family member been diagnosed with Hypertonic Cardiomyopathy?	☐	☐
23. Has any family member been diagnosed with Long QT Syndrome?	☐	☐
24. Has any family member been diagnosed with ion channelpathy (Brugada syndrome, etc.)?	☐	☐
25. Has any family member been diagnosed with Marfan's syndrome?	☐	☐
26. Have you had a severe viral infections (myocarditis, mononucleosis, etc.) in the past year?	☐	☐
27. Has a physician ever denied or restricted your participation in sports for any heart problem?	☐	☐
28. Have you ever had a head injury or concussion?	☐	☐
29. Have you ever had been knocked out, become unconscious or lost your memory?	☐	☐
30. Have you ever experienced a seizure?	☐	☐
31. Have you ever had numbness in your arms, hands, legs or feet?	☐	☐
32. Have you ever had a stinger, burner or pinched nerve?	☐	☐
33. Are you missing any paired organs?	☐	☐
34. Are you presently under a doctor's care?	☐	☐
35. Are you currently taking any prescription or nonprescription medications or inhalers?	☐	☐
36. Do you have any allergies?	☐	☐
37. Have you ever been dizzy before or during exercise?	☐	☐
38. Do you currently have any skin problems (itching, acne, warts, fungus or blisters)?	☐	☐
39. Have you ever become ill after exercising or working in the heat?	☐	☐
40. Have you ever had any problems with your eyes or vision?	☐	☐
41. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
42. Do you have asthma?	☐	☐
43. Do you have seasonal allergies that require medical treatment?	☐	☐
44. Do you use any special protective or corrective equipment?	☐	☐
45. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
46. Have you ever broken or fractured any bones?	☐	☐
47. Have you ever dislocated any joints?	☐	☐
48. Have you ever had any problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

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?	☐	☐
6. Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities?	☐	☐
7. Do you feel stressed out?	☐	☐
8. Have you been diagnosed with or treated for Sickle Cell Trait or Sickle Cell Disease?	☐	☐

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 **PHYSICAL 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: _____

For school use only:

This Medical History Form reviewed by: NAME: _____ DATE: _____