

Recommendation Information Sheet



K4 and Kindergarten

A recommendation is needed from a current or previous teacher at your child(ren)'s preschool or daycare. Please provide the name and email address of the person you would like contacted.

Preschool/Daycare Teacher _____

Email _____

If a child has not attended a daycare or preschool, a recommendation from another source, such as, a babysitter, Bible class teacher, or extracurricular activity instructor may be used. Please provide the name and email address of the person you would like contacted.

Affiliation _____

Email _____

My child is applying to attend Brentwood Christian School. As part of the BCS admissions process, the school requires a recommendation from a preschool/daycare teacher or affiliation.

Brentwood Christian School has my permission to send current preschool/daycare teacher or affiliation 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



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 _____

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Reason for giving medication _____
Amount to be given (dosage) _____ Time to be given _____
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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.