

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)
- ☐ 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.


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)

- had any chronic illnesses – i.e., Asthma, Diabetes, Cystic Fibrosis?
- had any allergies that require special attention or medication?
- had any past history of head injury, concussion, seizure, etc.?
- had any heart or blood pressure abnormalities?
- had any spinal injuries or spinal defects of any kind?
- had any need for medication at school?
- been exposed to tuberculosis?
- been subject to headaches?
- had any serious or significant accidents (give dates)?
- had any surgical procedures (give dates)?
- been prescribed corrective lenses (if so, date of last eye exam)?
- had any serious or significant dental needs?
- 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

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION

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.

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 channelopathy (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?

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

49. Do you want to weigh more or less than you do now?

50. Do you lose weight regularly to meet weight requirements for your Extra-Curricular Activities?

51. Do you feel stressed out?

52. 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?

4. How many periods have you had in the last year?

5. What was the longest time between period in the last year?

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.

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:



Previous Athletic Participation Form (PAPF)



Student Name: _____

Student Address: _____

New School: _____

Previous School: _____

Grades attended at previous school: 9 10 11 12 Grade at new school: 9 10 11 12

Date of acceptance at the new school? _____

Date of withdrawal from the previous school? _____

Date of first attendance at the new school? _____

CERTIFICATION OF FAMILY

We certify that neither my child nor I have been offered nor accepted any inducement to attend the new school in accordance with Section 87 of the TAPPS By-Laws. Additionally, my child is in compliance with all TRANSFER policies as outlined in Section 104 of the TAPPS By-Laws. The new school has presented information regarding TAPPS eligibility for our review prior to signature of this document. If unsure of compliance, please consult school Athletic Director prior to signature.

Parent / Guardian Signature / Date

Student Signature / Date

CERTIFICATION OF NEW SCHOOL

We certify that to the best of our knowledge, no one has offered any inducement to the student or parent to transfer to our school. We certify that the student was not induced by anyone. We reviewed all information and circumstances pertaining to this student's transfer to our school and certify that the TAPPS By-Laws have been upheld. The new school has presented information regarding TAPPS eligibility to the student and parents for review prior to signature of this document.

Head Administrator / Date

Athletic Director / Date

CERTIFICATION AND RELEASE BY PREVIOUS SCHOOL

We certify the following answers to be true and accurate to the best of our knowledge.

1. ☐ Yes ☐ No Was this student ever suspended or removed from an athletic program in your school?
2. ☐ Yes ☐ No Would the student have been prohibited from athletic participation at your school if not transferring?
3. ☐ Yes ☐ No Is the previous school an alternative school in which the student was placed?
4. ☐ Yes ☐ No Based on your knowledge, did the student participate on any AAU, club or similar team coached by a coach or faculty member at the new school?
5. ☐ Yes ☐ No Based on your knowledge, did the student participate on any off-season league team coached by a coach or faculty member at the new school?
6. ☐ Yes ☐ No Based on your knowledge, did the student participate in a camp or camps involving the new school or a coach or faculty member at the new school?
7. ☐ Yes ☐ No Based on your knowledge, did the student receive private or group training by a coach or faculty member at the new school?
8. ☐ Yes ☐ No Based on your knowledge did the student receive any offer of inducement, financial or otherwise, to attend the new school?

Head Administrator / Date

Athletic Director / Date

For Office Use Only

Date Received by TAPPS: _____ TAPPS Approval Date _____

TAPPS Office
3575 Lone Star Circle, Suite 414
Fort Worth, TX 76177
254-947-9268
info@tapps.biz

TAPPS Representative Signature

Participation Start Date/Entered into TAPPster



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