

CITY OF KNOWLEDGE SCHOOL

3285 N. Garey Ave. Pomona, CA 91767

Tel: (909) 392-0251

Fax: (909) 392-0295 www.Cityofknowledge.com

APPLICATION FOR ADMISSION

STUDENT INFORMATION

Student _____ **Grade**
Entering _____
Last First Middle
Address _____ City _____ Zip _____
Phone () _____ E-mail _____ Birthday _____
Birthplace _____ Age _____ Sex M F
City State Country

SCHOOL HISTORY

School last attended _____ Public _____ Private _____
Address _____ City _____ State _____ Zip _____
Grade in which enrolled _____ Phone () _____ - _____

List all the schools attended by the child

School	Address	Grade(s)	Year(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STUDENT DEVELOPMENTAL INFORMATION

Do any of following factors apply in your child's life: absence of father or mother, adoption, in -laws or grandparents in the home, unusual accidents or serious illness, disability, or other?

Comments _____

Does your child have any limitations, which would hinder him/her from normal progress in a regular classroom situation? If so explain _____

Has your child ever lived outside the United States? _____

If so, Where? _____ When & for How Long? _____

What is the predominant language in your home? _____

What language does the father speak? _____ Mother? _____

List languages in which your child is proficient _____

STUDENT INTERESTS

What are your child's favorite hobbies? _____

What are your child's favorite sports? _____

What are your child's special talents? _____

FAMILY INFORMATION

Father or Legal Guardian _____ Phone () _____ - _____

Address _____
Number Street City Zip

Occupation _____ Employer _____

Address _____ Phone () _____ - _____
Number street City zip

Mother's Name _____ Phone() _____ - _____

Address _____
Number Street City Zip

Occupation _____ Employer _____

Address _____ Phone () _____ - _____
Number Street City Zip

Relationship of Parents _____ Married _____ Divorced

Brothers and Sisters (Please list below)

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PARENT EXPECTATIONS

What are your expectations for your child's education at this school? _____

What do you feel are the responsibilities of the school? _____

What do you expect from the school in terms of discipline? _____

Are you interested in being an involved parent? If so, how would you like to contribute?

Are you interested in the school providing extracurricular activities for you child? If so, what Activities would you like to see made available? _____

APPLICATION STATEMENT

I hereby make this application for my Son/Daughter _____
(First name) (Last)

For grade _____ in CITY OF KNOWLEDGE SCHOOL for 200 - 200 school year.

I CERTIFY THAT ALL INFORMATION IN THIS APPLICATION IS CORRECT.

I UNDERSTAND THAT COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE ENROLLMENT OF MY CHILD IN CITY OF KNOWLEDGE SCHOOL.

I HAVE READ THE FEES SCHEDULE AND UNDERSTAND THAT PAYMENT IS REQUIRED FOR THE FULL SCHOOL YEAR AND THAT I CAN PAY THE FULL AMOUNT BY AUGUST 1ST OR I CAN MAKE 10 EQUAL PAYMENTS TO BE PAID ON THE 1ST OF EACH MONTH AUGUST THROUGH MAY.

(Signature of parent or guardian)

(Date)

IF YOU HAVE ANY QUESTIONS, OR NEED TO KNOW MORE INFORMATION, PLEASE CALL (909) 392-0251

City of Knowledge School

CHILD'S NAME _____

DATE _____ BIRTH DATE _____

HEALTH HISTORY

History to be filled out By Parent
Circle Correct Statements and Return to School When Completed

A- PREGNANCY AND BIRTH

Circle Correct Answer

- | | | |
|---|-----|-----|
| 1. Did you have an illness during your pregnancy? -----No | Yes | |
| 2. Did the baby come on time?----- | Yes | No |
| 3. What was the birth weight? ----- | | |
| 4. Did your baby have any trouble starting to breathe ? ----- | No | Yes |
| 5. Did the baby have any trouble while in the hospital? ----- | No | Yes |

B. FEEDING AND DIGESTION

- | | | |
|---|-----|-----|
| 1. Was there severe colic or any unusual feeding problems the first three months?----- | No | Yes |
| 2. Is your child's appetite usually good?----- | Yes | No |
| 3. Is it good now?----- | Yes | No |
| 4. Do any foods disagree with him/her?----- | No | Yes |
| 5. Does he/she often have diarrhea?----- | No | Yes |
| 6. Has constipation ever been much of a problem?----- | No | Yes |
| 7. Does he/she take vitamins with <input type="checkbox"/> Iron? <input type="checkbox"/> Fluoride? | | |
| 8. Does your child eat a wide variety of foods?----- | Yes | No |
| 9. Does your child frequently eat clay, paint chips, dirt or any thing else that is not
Usually considered food----- | No | Yes |
| 10. What type of milk is your drinking?----- | | |

C. FAMILY HISTORY

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, Brothers, sisters have had:
Tuberculosis, diabetes. Asthma. Heart disease, High blood Pressure, allergy, Seizures. Cancer, Mental illness, Inherited Diseases.
2. Are the child's parents born in good health?----- Yes No
3. Have any of your children died?----- No Yes

D. INFECTIONS. ILLNESSES. MISCELLANEOUS PROBLEMS AND DEVELOPMENT

- | | | |
|--|----|-----|
| 1. Has your child had as many as three bouts of ear trouble?----- | No | Yes |
| 2. Does he/she usually have more than three colds or throat infections a year with fever?
----- | No | Yes |
| 3. Does he/she have any trouble with urination?----- | No | Yes |
| 4. Has he/she ever had a convulsion?----- | No | Yes |
| 5. Does he/she had any trouble with his/her eyes?----- | No | Yes |
| 6. Does he/she hear well?----- | No | Yes |

- 7. At what age did he/she sit alone?-----
- 8. At what age did he/she walk alone?-----
- 9. Did he/she say any words by the time he/she was 1 1/2 years old?----- Yes No
- 10. Does he/she have any trouble sleeping now?----- No Yes
- 11. Circle any of the following that your child has had: "Red" or "hard" Measles, Whooping Cough, German Or three-day Measles, Serious Accidents, broken bones. Pneumonia, removal of Tonsils and Adenoids,
Other Operations _____
Other Diseases - What? _____
Hospitalization -What? _____

E. ALLERGIES

- 1. Has he/she ever had eczema or hives?----- Yes No
- 2. Has he/she ever had wheezing or asthma?----- No Yes
- 3. Does he/she tend to have a stuffy nose or constant cold?----- No Yes
- 4. Has he/she had any allergies or reactions to any medicines or injections, immunizations?
----- No Yes

F. EMOTIONAL PROBLEMS

- 1. Is he/she doing well in school?----- No Yes
- 2. Does he/she get along well with other children? ----- Yes No
- 3. Circle any of the following which your child has: Nail Biting, Thumb Sucking, Nightmares. Bad Temper. Irritable, Wets Bed. Won't mind, Cant Toilet Train, speech problems, Breath holding, Jealousy.

Date _____ Parent Signature _____

Authorization for Medication (s) to be taken During School Hours

The following section is to be completed by the PARENT:

School Name **City of Knowledge**

Child's Name _____
Last First Sex Birth date

Physician's Name Address () Telephone

I request that my child be assisted in taking the medicine(s) described below at school by Authorized persons as authorized by me and my physician (see below).

Date Parent/Guardian signature Home phone Emergency

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medicine: _____

Form: _____

Dose: _____

If medicine to be given DAILY, at what time ? _____

If medicine to be given "WHEN NEEDED,"
Describe indications: _____

How soon can it be repeated ? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other Information:

Date _____ Physician's signature _____