



# City of Knowledge School

ACCREDITED BY WESTERN ASSOCIATION OF SCHOOLS AND COLLEGES

3285 N. Garey Avenue, Pomona, California 91767 USA

Tel (909)392 - 0251 / Fax (909)392 - 0295

## K- 6<sup>th</sup> APPLICATION FOR ADMISSION

### STUDENT INFORMATION

Student \_\_\_\_\_ **Grade entering** \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Birthday \_\_\_\_\_ Grade Entering \_\_\_\_\_

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

Does any of following factors applies 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 20\_\_\_\_ - 20\_\_\_\_ 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.

\_\_\_\_\_  
(Signature of parent or guardian)

\_\_\_\_\_  
(Date)

IF YOU HAVE ANY QUESTIONS, OR NEED TO KNOW MORE INFORMATION, PLEASE CONTACT THE ADMISSIONS OFFICE AT (909) 392-0251



# City of Knowledge School

ACCREDITED BY WESTERN ASSOCIATION OF SCHOOLS AND COLLEGES

3285 N. Garey Avenue, Pomona, California 91767 USA

Tel (909)392 - 0251 / Fax (909)392 - 0295

## HEALTH HISTORY

History to be filled out By Parent

Circle Correct Statements and Return to School When Completed

CHILD'S NAME \_\_\_\_\_

DATE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

### 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? -----                           | <hr/> |     |
| 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<br>Usually considered food----- | No    | Yes |
| 10. What type of milk is your drinking?-----  | <hr/> |     |

### C. FAMILY HISTORY

- 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.
- Are the child's parents born in good health?----- Yes No
- 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?<br>----- | 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 have 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 \_\_\_\_\_