

**BAPTIST ACADEMY**

2565 S. Villa Avenue  
Indianapolis, IN 46203  
(317) 788-1587

**APPLICATION FOR STUDENT ADMISSION**

**K-3 / K-4 / K-5**

This application does *not* assure acceptance, but it does provide information upon which a decision will be based. The registration fee **must** accompany this form, and is **nonrefundable / nontransferable**.

**GENERAL INFORMATION ~ Please PRINT.**

Student's Last Name	First	Middle	Name responds to	Race	Sex

**ADDRESS**

**PHONE #**

Number and Street	City	State	Zip + 4	Home Phone

**PLACE OF BIRTH**

**DATE OF BIRTH**

City	County	State	Month	Day	Year

**CHILD'S SOCIAL SECURITY #**

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**Please indicate the program for which your child is applying**

*(Must be 3 years old and potty trained by August 1<sup>st</sup>)*    *(Must be 4 years old by August 1<sup>st</sup>)*    *(Must be 5 years old by August 1<sup>st</sup>)*

*\*\*K3/K4 class available pending enrollment*

\_\_\_ \*\*K3/K4 year old **half** day                      \_\_\_ K4 year old **half** day                      \_\_\_ K5 year old **half** day

Circle one                      3 or 5 days                      (5 days only)

\_\_\_ \*\*K3/K4 year old **full** day                      \_\_\_ K4 year old **full** day                      \_\_\_ K5 year old **full** day

Circle one                      3 or 5 days                      (5 days only)

Work Phone Numbers:    Father \_\_\_\_\_ Ext. \_\_\_\_\_    Mother \_\_\_\_\_ Ext. \_\_\_\_\_

Cellular Phone Numbers:    Father \_\_\_\_\_    Mother \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to child \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Please state the **name(s)** with whom the student resides:

- Mon \_\_\_\_\_
- Tues \_\_\_\_\_
- Wed \_\_\_\_\_
- Thurs \_\_\_\_\_
- Fri \_\_\_\_\_

Joint custody?    No \_\_\_\_\_ Yes \_\_\_\_\_

Name and address of non-custodial parent: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who will be financially responsible for the school bill?    Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**STUDENT INFORMATION**

**ACADEMIC**

Check the level of your child's potential academic ability:

\_\_\_ Superior      \_\_\_ Good      \_\_\_ Average

**SOCIAL/EMOTIONAL**

My child tends to be \_\_\_ outgoing    \_\_\_ shy    \_\_\_ withdrawn

**PHYSICAL**

Does your child have any mental, emotional or physical handicaps which may affect his/her activities or progress? No \_\_\_ Yes \_\_\_ If yes, give name of child and specific explanation \_\_\_\_\_

Does your child have ADD or ADHD? No \_\_\_ Yes \_\_\_

Have they been tested? No \_\_\_ Yes \_\_\_

Does your child take ANY medication(s)? No \_\_\_ Yes \_\_\_ If yes, please list below...

Name of medication \_\_\_\_\_ Treatment for \_\_\_\_\_

Name of medication \_\_\_\_\_ Treatment for \_\_\_\_\_

Name of medication \_\_\_\_\_ Treatment for \_\_\_\_\_

Does your child have any type of disability, allergies, seizures? No \_\_\_ Yes \_\_\_

If yes, what kind? \_\_\_\_\_

If necessary, do we have permission to give your child non-aspirin? No \_\_\_ Yes \_\_\_

<b>IMMUNIZATION REQUIREMENTS</b>			
<b><u>K3 / K4</u></b>		<b><u>K5</u></b>	
DTaP/DTP/DT/Td	4	DTaP/DTP/DT/Td	5
Polio	3	Polio	4
MMR	1	MMR	2
Hepatitis B	3	Hepatitis B	3
Varicella	2	Varicella	2

***Current immunization record and copy of birth certificate (prefer health department copy) MUST be received before enrollment is finalized.***