



# MIDWAY COVENANT CHRISTIAN SCHOOL

## SIBLING APPLICATION

**K4/3day K4/5day K5/half day K5/full day OR Rising \_\_\_\_\_ Grade**

### STUDENT INFORMATION

Name \_\_\_\_\_ Sex: \_\_\_\_\_ F \_\_\_\_\_ M  
Last First Middle

Name student goes by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

School previously attended \_\_\_\_\_

Is there anything about the last school year that Midway should know in order to best teach your child? \_\_\_\_\_

### SIBLINGS

Name	Age	Grade	School

### PARENT INFORMATION

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_  
If different from above

Address \_\_\_\_\_  
If different from above

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Email Address \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Business Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Marital Status \_\_\_\_\_

Marital Status \_\_\_\_\_

Student lives with \_\_\_\_\_ Dad \_\_\_\_\_ Mom \_\_\_\_\_ Both Parents

If divorced, are there restrictions on custody, visitation, etc. of which we should be aware?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please specify: \_\_\_\_\_

## **STUDENT HEALTH FORM**

Student's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

List any current health problems \_\_\_\_\_

\_\_\_\_\_

List any chronic health problems \_\_\_\_\_

\_\_\_\_\_

Does your child suffer from any of the followings?

Asthma \_\_\_\_\_ Hay Fever \_\_\_\_\_ Diabetes \_\_\_\_\_ Hypoglycemia \_\_\_\_\_

Allergies (please specify) \_\_\_\_\_

Does your child have any allergic reactions to any medicines? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Does your child have any physical limitations due to a physical handicap or an accident? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Does your child have any hearing difficulties? \_\_\_\_\_ Has a doctor been consulted? \_\_\_\_\_

What is being done to treat the disorder? \_\_\_\_\_

Does your child have any visual problems? \_\_\_\_\_ Has a doctor been consulted? \_\_\_\_\_

What is being done to treat the disorder? \_\_\_\_\_

Should your child wear glasses in school? \_\_\_\_\_

Does your child have any unusual health problems that the school should be aware of?

\_\_\_\_\_

Does your child have any physical, emotional or attention problems which require special medication or limited participation in certain activities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**Please include a copy of your child's CURRENT immunization record with the application.**