



East Dayton Christian School 2022-2023 Application for Admission

Please refer to the notes below before filling out the enrollment forms.

Please be advised:

- Students who have and/or had a pending case in the juvenile/adult court system due to legal offenses must first submit documentation for administrative review prior to submitting an enrollment or re-enrollment packet.
- If your child is currently receiving special education or intervention services that documentation (ETR and any IEP/SP/504 or School Accommodation plans) must accompany this application
- Admission is not considered complete without receipt of all official records from previous schools attended.
- Visible body piercings and/or tattoos are not allowed at EDCS.
- Parents/Guardians need to read the Parent-Student Handbook in order to sign the statement of cooperation that is on the bottom of the student information page. The handbook is located at www.eastdaytonchristian.org under the parent portal on the homepage.

Please Note: An official birth certificate, custody verification papers, application fee, the student and parent information forms, financial form, immunization authorization and records request - with all signatures, must accompany this application. Please give the Principal recommendation form to your current school's principal and bring it filled out to the EDCS office as soon as possible. A current doctor's physical, immunization records and the Emergency Medical Authorization is needed by August 1st.

Thank you!

Student Name: _____

Return this checklist with your enrollment packet.

EAST DAYTON CHRISTIAN SCHOOL NEW ENROLLMENT CHECKLIST K-12
2022-2023

Return completed forms and enrollment fee to the school office.

New Students:

- _____ Registration fee(Non-Refundable): \$100
- _____ Enrollment Application Form (Student/Parent Information forms)
- _____ Custody Verification Papers Included (if applicable)
- _____ Copy of Official Stamped Birth Certificate (Not Hospital Record)
- _____ Financial Form
- _____ Records Request
- _____ Student Recommendation Form
- _____ Student Medical Exam/Immunization Record (**Due Aug. 1st**) Must have to attend school.
- _____ Medical Forms (EMA & Health History Form)
- _____ K-6 Daycare Forms (if applicable)
- _____ Parent/Administration interview (to be scheduled) _____ Kindergarten only: Supply kit fee

All Students:

For all families applying for a state tuition voucher:

If you are applying for the Ohio EdChoice scholarship (voucher), **please check one:**

☐ I am a new applicant. ☐ I am a renewal.

(Incomplete packets will be returned for completion.)

STUDENT INFORMATION

Grade to Enter 2022-23 _____

Applicant Name: _____ Date of Birth _____

Last

First

Middle

Preferred Name _____ ☐ Male ☐ Female

Student Address: _____

Street

City

State

Zip

Primary phone number _____

Ethnicity: ☐ African-American ☐ Asian Hispanic/Latino American ☐ Indian/Alaska Native ☐ Caucasian

☐ Multiracial ☐ Native Hawaiian/Pacific Islander ☐ Other _____

Current School Attending _____

Public school district (**not county**) in which you currently live: _____

Has the student been retained, suspended, expelled, or asked to withdraw? If so, what grade? Please Explain.

Has your child ever been a student at East Dayton Christian School? _____ When? _____

School recommended by: _____ Reason for selecting this school _____

Name and grades of siblings attending our school: _____

Church Affiliation: _____

Does your child have any medical conditions or history of unusual physical or emotional condition which required professional attention? Please Explain _____

Emergency contacts: (Please list **full name/relationship** to student and **best phone numbers to call**)

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Is your student currently receiving or ever received special education/intervention services? ☐ Yes ☐ No

Is your student presently receiving speech services? ☐ Yes ☐ No

Is your student currently on an IEP/504 Plan? ☐ Yes ☐ No

***If yes, please include a plan with completed application for admission.**

****If no, have they been on a plan in the past?** ☐ Yes ☐ No

Student is applying for an EdChoice scholarship based on: (check one) ☐ school district ☐ income-based

STATEMENT OF COOPERATION

In making an application for my child, it is my desire to have him complete the school year 20__-20__. It is also my understanding that the policy of the school is to make no refunds on registration fees. I also give permission for my child to take part in school activities, including sports and school sponsored trips away from the school premises, and absolve the school from liability to me or my child because of any injury to my child at school or during school activities. I have read and agree to abide by the policies in the East Dayton Christian School parent/student handbook which includes, but is not limited to: EDCS Honor Code, Partnership Agreement, and Conflict Resolution. (The parent/student handbook is located at eastdaytonchristian.org under the parent portal on the homepage.)

Parent Signature _____ Parent Signature _____

Student Name _____

PARENT INFORMATION FORM

Biological Father

Name _____

Address _____

Employer _____

Position _____

Work Phone _____

Cell Phone _____

Email _____

Biological Mother

Name _____

Address _____

Employer _____

Position _____

Work Phone _____

Cell Phone _____

Email _____

Marital Status: ☐ Married ☐ Separated* ☐ Divorced* ☐ Single*

** If custody has been awarded to one parent or is shared, a copy of that document must be included with this application.*

Student Lives With:

☐ Both Parents ☐ Mother only ☐ Father only ☐ Guardian ☐ Mother and Step-Father

☐ Father and Step-Mother ☐ Foster Parents ☐ Other _____

Non-residential/Non-custodial parent (if applicable)

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Email _____

Does non-residential/non-custodial parent have visitation rights? ☐ Yes ☐ No

Does non-residential/non-custodial parent responsible for tuition? ☐ Yes ☐ No

Step-Parent Information (for those legally married/remarried)

Legal Step-Father's Name _____ Phone: _____

Legal Step-Mother's Name: _____ Phone: _____

*East Dayton Christian School does not discriminate on the basis of race, color, national and ethnic origin in admissions policies, scholarships, athletic and other school-administered programs. EDCS reserves the right to select students on the basis of academic performance, religious commitment, lifestyle choices, and personal qualifications including a willingness to cooperate with EDCS administration and to abide by its policies. (Romans 2:11)

Revised 12/20

East Dayton Christian School
Tuition/Fees 2022-2023

K-12th

New Student Nonrefundable Application Fee: \$100.00/student

Continuous Enrollment Fee(Returning Students): \$50.00 on/before 3/1/22

Tuition Rates: Yearly

K-8th Grade: \$5,500.00

High School: \$7,000.00

Intervention Services are \$100.00 per month per subject

K-6th: Before/After School DayCare Fees

Part Time \$15.00/day

Full Time \$150.00/month for 1 student

Family Rate: 2 students \$175.00/month

3 students \$200.00/month

4 students \$225.00/month

Tuition Payment Options: **check to select option**

☐ Monthly on FACTS 10 or 12 month plans June 2022 - May 2023

☐ Semi Annual Due 8/1 & 12/1 3% off

☐ Annual by 8/1 4% off

☐ Annual by 7/15 5% off

☐ I receive or am applying for Ohio Ed Choice

If East Dayton Christian School's tuition is higher than the Ed Choice scholarship amount and the family does not qualify for low income status(at or below 200% of the federal poverty guideline), the family will have to pay the difference.

****For any family withdrawing after March 1, 2022, 10% of gross annual tuition will be charged.***

Parent/Guardian Signature _____

Students Name(s) _____

East Dayton Christian School does not offer tuition assistance scholarships.



Equipping for Leadership and Service

Attn: Principals

Please send appropriate records including:

- Past grade history
- Standardized test scores, end of course test scores, proficiency test scores
- Discipline and attendance records
- Evaluation Team Report (ETR) and any IEP/SP, 504 Plan or School Accommodation plan (if applicable)
- Transcripts
- Student Recommendation for Admission
- Birth Certificate and Immunization Records

Send Student Records to:

East Dayton Christian School Admissions
999 Spinning Rd.
Dayton, OH 45431
937-252-5400
Fax: 937-258-4099
edcs@eastdaytonchristian.org

REQUEST FOR STUDENT RECORDS:

Fill in the required information, sign and submit this form with your application. Enrollment is considered incomplete without records.

Student Name: _____

Date of Birth: _____ Current Grade: _____

Student Address: _____
Street City Zip

I, _____ the parent/guardian of _____ request that
Printed Name Student

Current School

Current School Address

City

State

Zip

provide copies of school record information to East Dayton Christian School for the school's admission process.. The records should include copies of all school records including birth certificate, immunization records, standardized test scores, latest quarter grade report cards, attendance records, discipline records, IEP/Evaluation Team Report (if applicable) and State of Ohio Graduation Test scores. These records will be used for consideration of admissions and appropriate education placement.

Signature of parent or legal guardian _____

Date

Phone

Parents/guardians may inspect the records transferred or received. Records transferred by authorization of this release will NOT be released to another person, out of district school, or agency other than the one listed above without written notification to the parent or guardian.

STUDENT RECOMMENDATION
FOR ADMISSION TO EAST DAYTON CHRISTIAN SCHOOL
999 Spinning Rd., Dayton, OH 45431

INSTRUCTIONS TO PARENTS: Please complete items 1-4, then give this form to your student's principal or other authorized officer at his/her school. Your signature releases records and other evaluative data to East Dayton Christian School. **Registration is not complete without this information.**

- (1) Student's Name _____
- (2) Applying to grade _____ (3) Date _____
- (4) Signature of Parent/Guardian _____
-

This section is to be completed by the student's school principal or other authorized officer. This form assists in screening new applicants. The information gathered may or may not be shared with the student's parents/guardians. Principal should return form directly to East Dayton Christian School by mail or fax, 937-258-4099.

Name of School _____

How many years did the student attend? _____ What grades? _____

Reason for transfer: _____

Principal's Name _____ * If student has attended current school for less than 2 years, on a separate sheet of paper, please include the student's previous school information including name, address, phone number, principal's name, years attended, grade levels and reason for transfer.

Please answer the following questions regarding the above named student:

Does this student exhibit recurring disciplinary concerns? _____ Yes _____ No If yes, please explain:

To your knowledge, does this student use illegal drugs, alcohol, and/or tobacco? _____ Yes _____ No

If yes, please explain: _____

Has this student ever been suspended? _____ Yes _____ No If yes, please explain: _____

Has this student ever been expelled or asked to withdrawal? _____ Yes _____ No If yes, please explain:

Is this student frequently tardy to school and/or have frequent absences: _____ Yes _____ No

If yes, please explain: _____

Category	5	4	3	2	1	Rating
Integrity	Exceptionally Upright	Noticeably Upright	Upright, no cause to question	Weak or questionable	Record of dishonesty	
Leadership & Responsibility	Outstanding, top positions, contributes most	Commendable, top or next to top positions	Capable, minor positions	No sign or leadership or involvement	Record of irresponsibility	
Interest in Non-Academic Activities	Outstanding	Commendable, top or next to top positions	Active	Minor participation	No participation	
* Conduct	Outstanding in every aspect	Generally Excellent	Good or acceptable	Marginal	Poor or reprehensible	
* Respect for Authority	Works very well with those in authority	Works well with those in authority	Mild resistance to authority	Periodic rebelliousness to authority	Rebellious to authority	
Parental Support	Exceptional	Quite Good	Average	Sometimes Supportive	Often Unsupportive, critical of school	
Summary	Outstanding	Excellent	Good	Fair	Poor	

* These areas must be filled out by the person in charge of discipline.

For Private Schools:

Does this student's family take care of their financial obligations to your school in a timely manner?

_____ yes _____ no If no, please explain: _____

Does this student receive an EdChoice Scholarship? _____ yes _____ no

All Schools:

Additional comments about this student: _____

Completed by: _____ Title _____

Phone Number _____ Date _____

Ohio Department of Health • School and Adolescent Health

Physical Examination (Physician)

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

Speech/Language

Lead Poisoning

Speech assessment completed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Child has no discernible speech problem <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date _____ Type <input type="checkbox"/> C <input type="checkbox"/> V Results _____ µg/dL
Speech evaluation recommended <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculin Test Date _____ Type _____ Results _____
Child has possible problem with _____	

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

<input type="checkbox"/> Essentially normal <input type="checkbox"/> Abnormalities as follows _____ _____	
Is this child able to participate fully in: Classroom and academic activities <input type="checkbox"/> Yes <input type="checkbox"/> No Physical education classes <input type="checkbox"/> Yes <input type="checkbox"/> No Competition athletics <input type="checkbox"/> Yes <input type="checkbox"/> No Contact and collision sports <input type="checkbox"/> Yes <input type="checkbox"/> No	
If limitations are advised, please specify _____ _____	
Does this child have any physical, developmental or behavioral issues that may affect his/her educational process? _____ _____	

HealthCare Provider's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP

Authorization to Disclose Immunization Information

Name of Child _____

Date of Birth _____

I, _____, as the parent or guardian of the above named child, hereby authorize (Name of Provider[s]): _____

to disclose the specific and individually identifiable immunization records of the above named child to (Name of School): _____

for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the department of health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that above named child has been immunized, the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

(Signature of Personal Representative)

(Date)

(Relationship/ Authority)

NOTE: This Authorization was revoked on:

(Date)

(Signature of Staff)

REVOCATION SECTION

I do hereby request that this authorization to disclose immunization information of _____
(Name of Child/Patient)
signed by _____ on _____ be rescinded,
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)
effective _____.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

(Signature of Client/Patient)

(Date)

(Signature of Witness)

(Date)

(Signature of Personal Representative)

(Date)

(Relationship/Authority)

EMERGENCY MEDICAL AUTHORIZATION**2022-2023**

Student Legal Name (Last-First-Middle)			Birthdate
Address	City	Zip	School District
Grade	Home Room Teacher		Email address
Primary Contact Name	Mother/Guardian	Father/Guardian	
Place of Employment			
Cell #			
Home #			
Work #			

Authorized persons to assume responsibility for school dismissal and provisions of care when a parent/guardian cannot be reached:

1. _____ Phone _____ Relationship _____
2. _____ Phone _____ Relationship _____

Insurance: ☐ Private – Name _____ ☐ Medicaid/Medicare – Name _____ ☐ None

PART I OR PART II MUST BE COMPLETED**PART I: TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital/Emergency Room _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian _____ Date _____

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian _____ Date _____

IMPORTANT NOTE:

STUDENTS WILL NOT BE ALLOWED TO ATTEND CLASS UNTIL ALL FORMS ARE COMPLETED, SIGNED, AND RETURNED TO THE SCHOOL OFFICE. ADDITIONALLY, IMMUNIZATION RECORDS MUST BE ON FILE PRIOR TO THE FIRST DAY OF SCHOOL.

COMPLETE BOTH SIDES

Health History (Parent Fills Out)

Student's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:			<input type="checkbox"/> NO medical conditions		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia			
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions			
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems			
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury			
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)			
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____			

DOES YOUR CHILD HAVE ANY LIFE THREATENING ALLERGIES? ☐ YES ☐ NO

(If yes, please list and describe symptoms.) _____

DOES YOUR CHILD USE AN EPI-PEN? ☐ YES ☐ NO

Please list any prescription medication that your child takes on a regular basis.		
Medication and dose	Time	Reason

MEDICATION ADMINISTRATION

MEDICATION WILL NOT BE ADMINISTERED AT SCHOOL UNLESS FORM A AND FORM B HAVE BEEN SIGNED AND DATED BY THE PROVIDER AND PARENT.

I release and agree to hold the East Dayton Christian School Board, its officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian: _____ **Date:** _____

EDCS BEFORE/AFTER SCHOOL PROGRAM (One form per student)

For students in Kindergarten - 6th grade

2022-2023

Please check ALL that apply: ☐ AM only ☐ PM only ☐ Both ☐ Occasional ☐ Full-time

****Monthly form of payment:** ☐ Cash ☐ Check ☐ Facts (Automatic Withdrawal Payment Plan)

Daycare Fees are: \$150 - 1 student, \$175 - 2 students, \$200.00 - 3 students, \$225 - 4 students

***AM Daycare Begins at 6:30 a.m. in the Cafeteria - PM Daycare Ends at 5:30 p.m.**

Grade to enter for 2022-2023/yr _____ Gender: ____ Male ____ Female

NAME _____ GRADE _____

Mailing Address _____
Street City State Zip

Home Phone _____ Email address _____

With whom does the student reside: ☐ Parents ☐ Father ☐ Mother ☐ Guardian

Legal Guardian #1 (Name) _____ Relation to student _____

Cell # _____ Work # _____

Legal Guardian #2 (Name) _____ Relation to student _____

Cell # _____ Work # _____

Emergency Info: Physician _____ Phone _____

Names of other persons authorized to pick up student:

Name _____ Relation to student _____ Phone# _____

Name _____ Relation to student _____ Phone# _____

Name _____ Relation to student _____ Phone# _____

Estimated time of pick-up from daycare: _____

***Students must be picked up by 5:30 p.m. to avoid a \$2/min. Late pick-up fee**

Parent/Guardian Signature _____ **Date:** _____

****DAYCARE PAYMENTS ARE TO BE PAID ON THE FIRST OF THE MONTH TO AVOID A \$25.00 LATE FEE.**

SEPTEMBER THROUGH MAY