"Committed to excellence for the glory of God"

APPLICATION

A non-refundable application fee of $75 must accompany each application.

CHILD

Date _____ Phone ( ) _____

Full Name _____
LAST FIRST MIDDLE NICKNAME

Address _____
STREET CITY STATE ZIP CODE

Birth Date _____ Age _____ Birthplace _____

Religion _____ Place Of Worship _____

MOTHER

Full Name _____ Phone ( ) _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Place Of Employment _____ Title _____

Address _____ Phone ( ) _____

Email _____ Cell Phone ( ) _____

FATHER

Full Name _____ Phone ( ) _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Place Of Employment _____ Title _____

Address _____ Phone ( ) _____

Email _____ Cell Phone ( ) _____

STEP PARENT/GUARDIAN

Full Name _____ Phone ( ) _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Place Of Employment _____ Title _____

Address _____ Phone ( ) _____

Email _____ Cell Phone ( ) _____

FAMILY INFORMATION

PARENTS

Applicant is living with: ( ) Parents ( ) Father ( ) Mother

Other (please specify) _____

If applicant's parents are divorced, which parent has legal responsibility for:

School Related Decisions _____ School Bills _____

Custody of the Student _____ Receiving School Communications _____

What was your primary reason for selecting The Imani School **For Infants & Toddlers**?

_____

_____

_____

_____

SIBLINGS

Name	Age	Grade	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the child have relatives who attend or have attended The Imani School or The Imani School **For Infants & Toddlers?** _____ Yes _____ No If yes, please give names, relationships, and years attended:

_____

_____

_____

_____

MEDICAL HISTORY

Please describe any illnesses, diseases, physical abilities or special conditions, which either have affected or may affect your child's general health. (Example: Health, Hearing, Eyesight, Attention Deficit, Memory, Learning Difficulties, Allergies, Motor Difficulties, etc.)

_____

_____

_____

Have any behavioral, psychological or educational evaluations of your child been done? _____ Yes _____ No

If yes, why, when, and by whom?

_____

_____

(We may request from you a copy of the report.)

If applicable, what type of formula is the child on?

_____

Describe any special dietary concerns: _____

_____

Please Note: Under state law, the parent or guardian must provide The Imani School **For Infants & Toddlers** with a Physician's Report form no later than one week after the first day of attendance.

EMERGENCY CONTACTS

Additional persons who may be called in an emergency and who are authorized to take the child from the school. It is important that they are available during the school hours.

(a) Name _____ Relationship _____

Address _____ Phone _____ Work # _____ Cell # _____

(b) Name _____ Relationship _____

Address _____ Phone _____ Work # _____ Cell # _____

(c) Name _____ Relationship _____

Address _____ Phone _____ Work # _____ Cell # _____

HOURS

Number of days per week your child will attend _____

I will bring my child to school at about _____ a.m. I will pick up my child at about _____ p.m.

Date attendance will begin _____

THE IMANI SCHOOL For Infants & Toddlers

DESCRIPTION OF CHILD

Please describe your child as objectively as possible in the space below. Include information that will help us provide the best possible care for your child.

_____

_____

_____

_____

_____

_____

_____

I understand that there will be no refund of the application fee. You will find my attached check made payable to The Imani School **For Infants & Toddlers** for the application fee of $75.00.

Signature(s)_____

_____

The Imani School For Infants & Toddlers

"Committed to excellence for the glory of God"

PLEASE ADDRESS CORRESPONDENCE TO:

Director of Admissions
The Imani School
12401 South Post Oak Road
Houston, Texas 77045

(713) 723-0616 Office
(713) 723-6143 Fax
www.imanischool.org

FOR OFFICE USE ONLY

Date Registration Packet Received _____

Date Application Fee Received _____

Date Child Enrolled _____

Date Child Withdrew _____

Entry Date _____

Accepted ( ) Yes ( ) No

Comments _____

_____

Homeroom _____

NOTICE OF NON-DISCRIMINATION POLICY:

THE IMANI SCHOOL FOR INFANTS & TODDLERS DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL OR ETHNIC ORIGIN IN ADMISSION OF STUDENTS OR IN THE ADMINISTRATION OF ITS PROGRAMS.

The Imani School For Infants & Toddlers

"Committed to excellence for the glory of God"

MEDICAL DATA FORM

THIS FORM SHOULD ACCOMPANY THE ADMISSION APPLICATION

Date _____

Full Name _____
LAST FIRST MIDDLE NICKNAME

If your child appears ill, has a high fever, is vomiting, or shows evidence of a communicable disease, please leave him at home. If your child has such symptoms and is present at The Imani School **For Infants & Toddlers,** you will be asked to pick him up immediately. This requirement is imposed by the State Department of Human Resources.

Under state law, the parent or guardian must provide The Imani School **For Infants & Toddlers** with a Physician's Report form no later than one week after the first day of attendance.

Physician _____Office # _____

Address _____
STREET CITY STATE ZIP CODE

Family's Health Insurance Carrier:_____ Policy Number_____

It is understood that a conscientious effort will be made to notify me or my spouse. If it is impossible to locate me or my spouse, the expense of any emergency service will be accepted by me.

I give permission for my child to take part in all activities; including field trips away from school. In the event of an accident or emergency, if my child's physician is not available, I hereby grant permission to call another licensed physician. I hereby authorize the bearer of this slip to authorize medical treatment by the emergency room physician or whom he deems necessary for my child(ren).

Parent/Guardian _____ Date _____

Parent/Guardian _____ Date _____

HEALTH RECORD

Please have this form completed by a licensed health professional:
ATTACH A COPY OF THE CURRENT
IMMUNIZATION RECORD TO THIS FORM

Child's Name_____

Is the child able to participate in the normal activities of a school program?
❒Yes ❒No

Are there any restrictions on normal activities? ❒Yes ❒No
If yes, please specify:_____

Does the child have any chronic medical condition that necessitates special attention? ❒Yes ❒No
If yes, please specify:_____

Is the child taking any medication prescribed for long term continous use?
❒Yes ❒No
If yes, please explain:_____
_____
_____

Has the child been hospitalized during the past 12 months? ❒Yes ❒No
If yes, please explain:_____
_____
_____

Known Allergies: _____

Dietary Restrictions: _____

_____
Physician's Signature **Date**

_____
Parent's Signature **Date**

Please return this form with your child's current immunization record to the front office or fax them to: 713-723-6143