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The

Renaissance

Preparatory

Academy

**Curiosum**

**Humanitas**

**Fortitude
Opus**

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Myrtle Beach, SC 29588

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# New Student Enrollment Form

We welcome your family and student to theThe Renaissance Preparatory Academy family!

Please confirm in writing that you wish your child to be enrolled in The Renaissance Preparatory Academy and that you have included the following files or evidence of payment of:

[ ]  **The Medical Background Form** (later in this document).

##### [ ]  **Uniform Agreement/Order Form (separate file)**

##### [ ]  **Tuition Agreement and Commitment Form (separate file)**

##### [ ]  **Registration Fees (Books, Location, and Registration)**

##### [ ]  **Tuition Deposit (10% of Tuition Bill)**

## **PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_
Parent/Guardian 1 Signature Date Parent/Guardian 2 Signature Date

OFFICE USE ONLY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| School/classChoose an item. | Term Click here to enter text. | Start Date Click here to enter a date. | Program/GradeChoose an item. | School Year2017-2018 |

# Medical Background Form

To enable us to have a safe and healthy an environment for your child and all our students, we ask that you complete the following medical information.

**Childhood Health History**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Last*** NameClick here to enter text. | First NameClick here to enter text. | Middle NameClick here to enter text. | NicknameClick here to enter text. |
| Date of BirthClick here to enter a date. | GenderChoose an item. | Today’s DateClick here to enter a date. |
| **Child’s Health History** |
| Name of Doctor/Clinic:Click here to enter text. | Address/City/ StateClick here to enter text. | PhoneClick here to enter text. |
| Were there any significant problems during pregnancy or birth? [ ] NO [ ] YES, Please Explain: |
| Click here to enter text. |
| Has your child had surgery or been hospitalized? [ ] NO [ ] YES, Please Explain: |
| Click here to enter text. |
| Date last seen by a healthcare provider (for reasons other than immunizations): Click here to enter a date. |

**Medication**

|  |
| --- |
| Does your child take medication on a regular basis? [ ] NO [ ] YES, Please Explain: |
| Why? Click here to enter text. |
| Names of medication(s), dosage and when taken: Click here to enter text. |
| Has your child had any of the following? |  | Age of child or date of incident |
| Asthma | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Other breathing problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Seizures or other neurological problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Heart or other cardiovascular problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Bladder or urinary tract problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Bowel or other GI problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Bone or joint problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Eczema or skin problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Frequent ear infections or tubes | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Other ear, nose, or throat problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Tuberculosis exposure | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Chicken Pox or vaccination for such | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Diabetes or other endocrine problems | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Injury or abuse | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Car sickness | [ ] NO  | [ ] YES, describe: Click here to enter text. |
| Other describe: Click here to enter text. |
|  |

**Nutrition History**

Is there any food or drink that your child should not ear for cultural, religious, personal reasons or medical reasons **other than allergies**? ***(Note: use the allergy chart on the next page to list any allergies to food or drink.)*** [ ]  YES: list below [ ]  NO, skip to next question

|  |  |
| --- | --- |
| Name of Food/Drink | Reason |
| Click here to enter text. | [ ] Cultural [ ] Religious [ ]  Personal [ ]  Medical/describe |
| Click here to enter text. | [ ] Cultural [ ] Religious [ ]  Personal [ ]  Medical/describe |
| Click here to enter text. | [ ] Cultural [ ] Religious [ ]  Personal [ ]  Medical/describe |
| Click here to enter text. | [ ] Cultural [ ] Religious [ ]  Personal [ ]  Medical/describe |
| Click here to enter text. | [ ] Cultural [ ] Religious [ ]  Personal [ ]  Medical/describe |
| Does your child have any problems with chewing or swallowing? [ ] NO [ ] YES, Please Explain: |
| Click here to enter text. |
| Check the box if you have concerns about your child’s  |  [ ]  eating habits [ ]  Height [ ]  Weight |
| Please Describe: Click here to enter text. |

**Allergy History**

Does your child have allergies or reactions (including intolerances) to food, medicine, insects, animals or other substances? [ ]  YES: list below [ ]  NO, skip to next question

**Allergy Chart** : Note: If your child has a food or milk allergy, we must have written documentation of the allergy from the doctor. For milk allergies, the doctor must also name a substitute for the milk.

|  |  |
| --- | --- |
| Do you keep epinephrine (epi-pen) available at home for your child’s allergy? | [ ]  YES[ ]  NO |
|  |
| **List each allergy or food separately** | **Briefly check symptoms or clarify under food item listed** | **Potential Severe Reaction\*** | **Doctor/ Date of Diagnosis** |
| Click here to enter text. | [ ]  Hives | [ ]  Wheezing | [ ]  Runny Nose | [ ]  Shortness of Breath | [ ]  YES | [ ]  NO | Click here to enter text.Click here to enter a date. |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| **List each allergy or food separately** | **Briefly check symptoms or clarify under food item listed** | **Potential Severe Reaction\*** | **Doctor/ Date of Diagnosis** |
| 1. Click here to enter text.
 | [ ]  Hives | [ ]  Wheezing | [ ]  Runny Nose | [ ]  Shortness of Breath | [ ]  YES | [ ]  NO | Click here to enter text.Click here to enter a date. |
| 1. Click here to enter text.
 | [ ]  Hives | [ ]  Wheezing | [ ]  Runny Nose | [ ]  Shortness of Breath | [ ]  YES | [ ]  NO | Click here to enter text.Click here to enter a date. |
| 1. Click here to enter text.
 | [ ]  Hives | [ ]  Wheezing | [ ]  Runny Nose | [ ]  Shortness of Breath | [ ]  YES | [ ]  NO | Click here to enter text.Click here to enter a date. |

***\*If the allergy has the potential to be severe, the child’s health care provider should complete a medical statement and an allergy care plan should be completed.***

|  |
| --- |
| Additional information about allergies: |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |
| 1. Click here to enter text.
 |

**Dental History**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of dentist:Click here to enter text. | Date last seen by dentist:Click here to enter a date. | City/State:Click here to enter text. | Phone Number:Click here to enter text. |
| How would you rate your child’s dental health? | [ ] Very Good | [ ] Good | [ ] Fair | [ ] Bad | [ ] Very Bad |
| Has your child ever had an injury to the teeth or gums?Describe: Click here to enter text. | [ ] NO | [ ] YES |
| Has your child complained about pain in the teeth or gums? | [ ] NO | [ ] YES |
| Is there fluoride in the water at your home, or is your child taking a prescribed fluoride supplement? | [ ] NO | [ ] YES |

**Parental Health Concerns**

|  |  |  |
| --- | --- | --- |
| Do you have any concerns about your child’s vision?Explain: Click here to enter text. | [ ] NO | [ ] YES |
| Do you have any concerns about your child’s hearing?Explain: Click here to enter text. | [ ] NO | [ ] YES |
| Do you have any concerns about your child’s speech?Explain: Click here to enter text. | [ ] NO | [ ] YES |
| Do you have any concerns about your child’s behavior?Explain: Click here to enter text. | [ ] NO | [ ] YES |
| Do you have any concerns about your child’s development?Explain: Click here to enter text. | [ ] NO | [ ] YES |
| Do you have any other concerns about your child?Explain: Click here to enter text. | [ ] NO | [ ] YES |

|  |
| --- |
| Additional information regarding concerns: Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |