

2019-2020 School Year

**Cross of Hope Elementary School**

6104 Taylor Ranch Rd. NW

Albuquerque, NM 87120

(505) 897-1832 fax: (505) 924-0250

[school@crossofhope.org](mailto:school@crossofhope.org)

Hours: Mon-Thurs 8am-3:15pm, Fri 8am-12pm

www.crossofhope.org/schools/elementary

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| --- |
| Student Application Form |

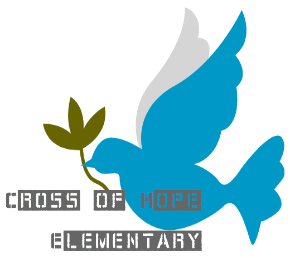
K-5th grades: a $150 **non-refundable** registration fee and a $200 book and supply fee must accompany this application

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| Student Information |

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| --- | --- |
| Name of Student (First/Middle/Last) | Date of Birth Gender  Male  Female |
| Home Address: (Address, City, State, Zip) | Home Phone # |
| Ethnic Origin (optional): African American  American Indian Asian Caucasian  Hispanic Other | Student Lives With: Mother Father  Both Parents Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Language(s) Spoken at Home:  English Spanish French Hindi  Chinese German Other­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Church Affiliation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Student attends Church Yes No |

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| Parent Information |

|  |  |
| --- | --- |
| **FATHER**  or Stepfather Guardian | **MOTHER** or Stepmother Guardian |
| Name: Cell/Hm#: | Name: Cell/Hm#: |
| Employer | Employer |
| Employer Address | Employer Address |
| Home Address (If different from Student) | Home Address (If different from Student) |
| Married Divorced Separated  Remarried Widowed | Married Divorced Separated  Remarried Widowed |
| Email Address: | Email Address: |
| Financial Responsibility? Yes No | Financial Responsibility? Yes No |

 Has the student previously attended another school? (If yes, complete below)

Previous Schools

Is the Student a:

-COH Preschool Student? \_\_\_\_\_\_\_ Years attended\_\_\_\_\_\_\_\_\_\_\_\_\_

-Member of Cross of Hope Lutheran Church? \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| School Name: Phone# | School Address: (Street, City, State, Zip) |
| Dates attended: | Grade Completed: |

|  |
| --- |
| Family Information |

|  |  |  |  |
| --- | --- | --- | --- |
| **Brother(s) & Sister(s) Names** | **Age** | **Grade** | **School Attending** |
|  |  |  |  |
|  |  |  |  |
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| --- |
| Emergency Contacts |

**#1**

|  |  |
| --- | --- |
| Name | Relationship to Student |
| Address | Cell/HM Phone# |

**#2**

|  |  |
| --- | --- |
| Name | Relationship to Student |
| Address | Cell/HM Phone# |

**#3**

|  |  |
| --- | --- |
| Name | Relationship to Student |
| Address | Cell/HM Phone# |

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| Family Enrollment Agreement |

We as a family will….

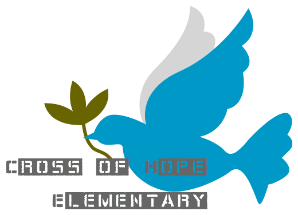
* Understand that weekly chapel, memorizing parts of the Bible, Christian Studies curriculum and the Christian environment is an integral part of the school
* Ensure that my child attends school at least 95% of the time (9 absences or less per year)
* Make sure my child is not tardy to school and stays in school until school is dismissed every day
* Comply with the school’s early drop-off/late pick-up rule; students are not permitted in the building or on school grounds before 7:45am unless a special school function dictates necessity and if my child is picked up more than 15 minutes late from the end of the school day, a fee of $5.00 for every 10 minute period will be charged to the students account due to additional supervision required.
* Support the school discipline policy as described in the Parent/Student Handbook
* Attend all school conferences (Orientation Night, Parent/Teacher Conferences, Curriculum Night, Math Night, etc.)
* Communicate with the school about my child’s progress
* Support classroom homework policies
* Read with my child at least 15 minutes daily for Kindergarten – 3rd grade and discuss current readings-

4th and 5th grade

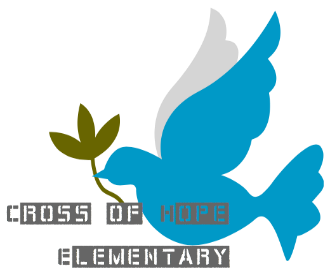
* Support the mission and vision of Cross of Hope Elementary School
* Agree that if there are any concerns with the school we will take these appropriate steps to resolve them: 1) speak with students’ teacher, 2) speak with teacher and principal and 3) arrange to speak with the COHES School Board of Management. If for any reason we are unable to find resolution it may be in the best interest of all parties that the school withdraws the child so that the situation remains manageable
* Understand that all new students are on a thirty (30) day probationary period to determine if the school fits the needs of the child
* Agree as a condition of enrollment to pay the tuition and fees. We understand that these fees are due and payable in order for our child to remain in school. We also understand that a thirty (30) day written notice or one month’s tuition is required for withdrawal or disenrollment of my child and that book and supply fees for the following year are not refundable after the last day of the current school year
* Understand that tuition may be paid in full by the last day of the current school year to receive a discount. COHES has a monthly payment program that is processed through FACTS Tuition Management Company and requires automatic withdrawal from a checking or savings account. More information about FACTs can be obtained from the school office

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Parent/Guardian Printed Name Date



Parent/Guardian Signature



Medical Information

**In the event of an emergency school personnel will take these steps if necessary:**

1. Attempt to contact parent or guardian.
2. Attempt to contact you through any of the persons listed as an Emergency Contact that you provide
3. If the school cannot contact you, the school may do any of the following:

* Call 911
* Call an ambulance
* Have the child taken to an emergency hospital

   Expenses are not covered by the school's insurance policy and costs may be incurred by the family. Your insurance company name, address and policy number are required to be able to care for your child in an emergency.

   Cross of Hope Elementary is not responsible for anything that may happen as a result of false information given at the time of enrollment or if you do not keep the school updated on changes.

**Insurance:**

|  |  |
| --- | --- |
| Med. Insurance Company | Policy Number |
| Dental Insurance Company | Policy Number |

**Students Physician:**

|  |  |
| --- | --- |
| Doctor’s Name | Phone |
| Address | Email |

**Student’s Dentist:**

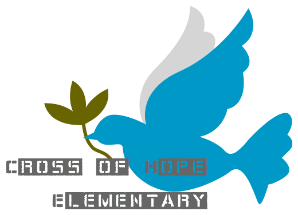
|  |  |
| --- | --- |
| Dentist’s Name | Phone |
| Address | Email |

**Desired Hospital in Case of Emergency:** Rust Medical Lovelace Westside UNMH

Emergency Agreement

**I (we) grant permission for authorized school personnel to take whatever steps necessary to obtain medical care for my child if warranted.**

**Parent/Guardian Signature Date**



To the best of your knowledge answer the following about your child and ensure its accuracy, correctness and completeness. If you answer “yes” to any, please explain

Health History Questionnaire

**Health History:**

Asthma Yes No

Health History Explanations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Trait Yes No

Congenital Defect Yes No

Convulsions Yes No

Depression Yes No

Diabetes Yes No

Epilepsy Yes No

Hay Fever Yes No

Hepatitis Yes No

Chicken Pox Yes No

High Blood Pressure Yes No

Migraines Yes No

Nervous Stomach Yes No

Rheumatic Fever Yes No

Sinus Trouble Yes No

Thyroid Yes No

Mental Health Yes No

Hyperactive Yes No

Other­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check if applicable:**

Heart: Rheumatic Frequent infection Valve Problem Murmur

Ears: Hearing Aid Frequent infection Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General: Appendix Bladder Eye Glasses Crutches Incontinence Speech Difficulties Wheel Chair Non-Correctable Visual Problems Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Special Needs:**

**Food Restrictions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

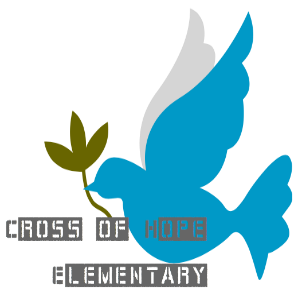
Please list and explain any problems that may require special attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any prescription medications being taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Please note that students on any medication MUST have a medical authorization form signed and on file*.)

Parent/Guardian Signature Date



Integrity Statements

Cross of Hope Elementary School admits students of any race, color, national and ethnic origin and grants, to all, the rights, privileges, programs and activities generally accorded or made available to any students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admission policies, tuition assistance programs, athletic or other school administered programs.

**Applicants’ Affidavit:**

“*I hereby confirm that all information provided by me in this application is accurate and complete to the best of my knowledge. I understand that all information in this document will be used for the care and education of my child and that only approved COHES staff has access to it. I attest that I have not willfully provided false or misleading information about me or my child as pertains to medical health, financial responsibility, guardianship or parental rights as decided by a court of law, contact information, physical address or any other information that may identify me, my child or the well- being of each of us. By affixing my signature to this page I agree that if any information provided is found to be willfully false that it may affect my child’s acceptance into Cross of Hope Elementary or after enrollment my child may be withdrawn from the school if deemed necessary by the school’s Principal and/or the COHES Board of Management.”*

Parent/Guardian’s Signature Date