



APPLICATION FOR ADMISSION
ACADEMIC YEAR 2010 - 2011

1640 Fell Street | Enumclaw, Washington 98022 | (360)825-8080 | www.cedarriveracademy.com

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INTRODUCTION TO THE ADMISSIONS PROCESS

Cedar River Academy accepts applications for students as young as three years, when their birthday is before August 31st as long as they have completed toilet training.

Cedar River Academy follows a formal admissions process for prospective students. The process starts with a visit by parents or guardians to our campus and classrooms, including discussions with the Curriculum Director, instructional staff, and other administrative personnel. Prospective students spend part of a day in a Cedar River Academy classroom to determine compatibility between the school and the student's family. No achievement or IQ testing is conducted to limit enrollment. When a mutual enrollment decision is made, the parent will complete this Application for Admission and submit it to our admissions department. The application will be promptly reviewed by the Curriculum Director and review of any prior school records will be completed. Notification of determination will then be sent to the applicant. An Enrollment Agreement is executed upon student enrollment.

STUDENT INFORMATION

First Name	Middle	Last	Generation	Alias
Nick Name	Tribe or Clan		Grade	
Homeroom	Passcode	Date Enrolled	Birth Date	Sex Race
Street Address	Apt. #	City	State	Zip County
Phone (home)	Email			

For Admissions Use Only

Status: Regular Acad. Probation Att. Probation Beh. Probation Other Probation
 Exchange Guest Other

Transfer Type: Local Public In-State Public Out-State Public Local Private In-State Private
 Out-State Private Local Sect Private In-State Sect Private Out-State Sect Private
 Other Country

PRIMARY PARENT/GUARDIAN INFORMATION

Full Name	Relationship to Student
Home Address (Including city, state and zip code)	
Email Address	
Primary Phone	Secondary Phone
Occupation	Employer/Company

ADDITIONAL PARENT/GUARDIAN INFORMATION

Full Name	Relationship to Student
Home Address (Including city, state and zip code)	
Email Address	
Primary Phone	Secondary Phone
Occupation	Employer/Company

EMERGENCY CONTACTS

First Name	Last Name	Relationship to Student				
Street Address	Apt. #	County	City	State	Zip	
Email Address						
Primary Phone	Secondary Phone		Contact Type			

FAMILY INFORMATION

Who has legal custody of this child?

Who should receive correspondence?

SIBLINGS OF APPLICANT

Name	Age	School
Name	Age	School
Name	Age	School
Name	Age	School

PERSONS AUTHORIZED TO PICK UP STUDENT

Full Name	Relationship to Student
Primary Phone	Secondary Phone
Full Name	Relationship to Student
Primary Phone	Secondary Phone
Full Name	Relationship to Student
Primary Phone	Secondary Phone

Message to Parents: To protect students, CRA implements strict check-in/check-out policies. In the space below, please select a “**code word**”. Anyone picking up your child will need to relay this **code word** to staff member on check-out duty. If the adult does not know this **code word**, CRA will not release the student.

Code word for current school year	Clue
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STUDENT HEALTH INFORMATION

Lives With		Month Began Walking		Month Began Talking		Birth Order	Children
		Yes	No	Yes	No		
Height	Weight	Hair Color	Eye Color	Wear Glasses?	Contact Lenses?	Birth Marks	
Blood Type							
Other Medical Apparatus? (braces, hearing aid, etc.)				Yes		No	
Date of Last Physical Exam		Name of Physician		Any Problems Noted?			
If Yes, Please Explain				Yes		No	
Date of Last Eye Exam		Name of Optometrist		Any Problems Noted?			
If Yes, Please Explain				Yes		No	
Date of Last Hearing Exam		Name of ENT		Any Problems Noted?			
If Yes, Please Explain				Yes		No	
Date of Last Hearing Exam		Name of ENT		Any Problems Noted?			
If Yes, Please Explain				Yes		No	
Does Student have		life-threatening medical conditions?		If Yes, Please Explain			

INSURANCE INFORMATION

Insurance Company	Group Name and Identification Number(s)
Subscriber Name	Company Telephone Number

FAMILY DENTAL PROVIDER

Dentist's Name	Telephone	
Number of Teeth	Number of Permanent Teeth Lost	Number of Teeth Decayed

ALLERGIES

Does your child suffer from allergies? Yes No If so, please describe any allergies to the following:

Medications	Reaction(s)
Reaction(s) Managed By	
Foods	Reaction(s)
Reaction(s) Managed By	
Other Allergies	Reaction(s)

Reaction(s) Managed By

DIETARY EXCLUSIONS

- Red Meat Pork Poultry Seafood Dairy Eggs Other

Food Dislikes

MEDICATIONS: (PLEASE INCLUDE NON-PRESCRIPTION DRUGS TAKEN ROUTINELY)

Medication #1	Dosage	Time(s) Taken Each Day
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Reason

Medication #2	Dosage	Time(s) Taken Each Day
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Reason

Attach additional pages if necessary.

All medication, either prescription or over-the-counter, to be administered during school hours must comply with our Health Policy guidelines, and include all required completed Medication Authorization Forms prior to our being able to accommodate your request.

HEALTH QUESTIONS

Yes answers require explanation. Please attach a separate sheet of paper with explanation.

Has/does your child:

- | | | |
|------------------------------|-----------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recently had an injury, illness, or infectious disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have a chronic or recurring illness/condition? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been hospitalized? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had surgery? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have frequent headaches? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had a head injury? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been knocked unconscious? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had broken bones or dislocations? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had any sprains or ligament/tendon problems? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had frequent ear infections? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have frequent throat infections? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever passed out during or after exercise? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been dizzy during or after exercise? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had seizures? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been diagnosed with hemophilia? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had chest pain during or after exercise? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had high blood pressure? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had a hernia? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been diagnosed with heart problems including a murmur? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had back problems? |

- | | | |
|------------------------------|-----------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had problems with joints (knees, ankles)? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have any skin problems? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever been diagnosed with diabetes? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have asthma? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Had mononucleosis in the past 12 months? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have problems with diarrhea/constipation? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have problems with sleepwalking? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have a history of bed-wetting? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had an eating disorder? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had kidney/urinary tract problems? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ever had emotional difficulties for which professional help was sought? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Had a recent case of head lice? |

LIST DATE OF ALL ILLNESSES THAT APPLY:

- | | |
|-----------------------------------------|-------------------|
| <input type="checkbox"/> Measles | Date (Mo/Yr)_____ |
| <input type="checkbox"/> Chickenpox | Date (Mo/Yr)_____ |
| <input type="checkbox"/> German Measles | Date (Mo/Yr)_____ |
| <input type="checkbox"/> Mumps | Date (Mo/Yr)_____ |
| <input type="checkbox"/> Hepatitis A | Date (Mo/Yr)_____ |
| <input type="checkbox"/> Hepatitis B | Date (Mo/Yr)_____ |
| <input type="checkbox"/> Hepatitis C | Date (Mo/Yr)_____ |

IMMUNIZATIONS

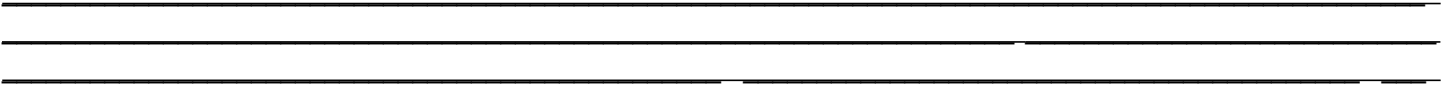
Cedar River Academy requires parents/guardians to attach a current Certificate of Immunization Status.

Type	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
MMR					
Diphtheria					
Pertussis					
Haemophilus					
Polio					
Tetanus					
Pneumococcal					
Varicella					
Hepatitis A					
Hepatitis B					

Last TB Mantous Test Date: _____ Result: Positive Negative

ADDITIONAL INFORMATION

Provide any additional information about your child's behavior and physical, emotional, or mental health that Cedar River Academy should know: _____



Explain any life threatening medical condition of the student: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, _____, am the parent/guardian of _____
In case of emergency, I understand that every effort will be made to contact me or my designated alternative. In the event I cannot be reached, I consent for my child to receive medical or surgical treatment as deemed necessary for his/her safety and welfare.

I hereby give Cedar River Academy my permission to secure proper treatment, including hospitalization, anesthesia, surgery or injections for my child. I will assume liability for any medical expenses involved.

I understand that in the event of an emergency, my child will receive treatment as determined by medical first responders, if present, or the nearest emergency facility.

Signature of Parent/Guardian Date

Application Fee Acknowledgment

Yes, I have enclosed my non-refundable application fee of \$50.

Name of person completing this form Signature Date

How did you learn of Cedar River Academy? Please check all that apply.

- CRA Family CRA Website Open House Billboard Newspaper
- Yellow Pages Mailing Reputation Other (please specify) _____

Non-Discrimination Policy

Cedar River Academy does not discriminate on the basis of race, color, national or ethnic origin, religion, gender, disability, or other legally protected status in admission of otherwise qualified students, or in providing access to the rights, programs, or activities generally available to all students and their families, including educational policies, financial aid, and other school administered programs.

STUDENT INFORMATION FOR OFF-CAMPUS ACTIVITIES

A copy of this form will be kept in a "Being-There" backpack, to be taken on all off-campus outings, in case of emergencies.

Student Name

Primary Parent/Guardian Information

Full Name Relationship to Student

Home Address (Including city, state and zip code)

Phone (home) Phone (work) Phone (cell)

Secondary Parent/Guardian Information

Full Name Relationship to Student

Home Address (including city, state and zip code)

Phone (home) Phone (work) Phone (cell)

PERMISSION FOR CHILD TO PARTICIPATE IN OFF-CAMPUS ACTIVITIES

Cedar River Academy's curriculum incorporates several field trips, or "Being-There" experiences, per term. All children attending CRA should participate in these and other off-campus activities. Parents will be notified of planned being-there experiences and other off-campus events through class calendars and communications distributed by teachers.

Signing below authorizes your child to participate in off-campus learning activities, unless otherwise expressly stated.

Signature of Parent/Guardian

Date

PARENT QUESTIONNAIRE

Applicant Name

Applying to Grade

1. Describe your child's experience with playgroups or other school-like settings.

2. Does your child have a particular area of strong interest? If so, please describe.

3. Describe your child's personality.

4. How does your child handle transitions (time to clean up, go to bed, etc.)?

5. Why do you feel Cedar River Academy would be a good match for your child?

6. Has your child received any special support services or tutoring? If so, please describe.

7. Please describe your goals for your child in the coming years.

Printed Name

Signature

Date

Teacher Questionnaire

To the Parent: Please read and sign the statement below.

_____ is applying to enter grade _____ at Cedar River Academy. Please assist in the application process by completing the questionnaire below.

Parent/Guardian Signature

Date

To the Teacher: The above student has applied for admission to our school. The admission committee would greatly appreciate your comments on this student in the following areas. Please answer the questions based on your personal experience with the applicant. Give specific descriptions whenever possible.

Please return this form as soon as possible using the enclosed, pre-addressed envelope. Thank you for your time and assistance.

Person completing this form _____

Relationship to Applicant _____

How long have you known the Applicant? _____

1. Does this child demonstrate appropriate self-help skills (hand washing, bathroom skills, etc.)?

2. Describe the level of fine motor control that this child displays.

3. Describe the level of large motor control that this child displays.

4. How does this child relate to other children?

5. How does this child relate to adults?

6. How does this child handle transitions?

7. Describe this child's behavior in group situations.

8. What strengths does this child demonstrate?

9. Are there any areas of concern (emotional, social, academic, etc.)?

10. Please include any additional comments here.

Is there any additional information that would be better conveyed in a phone conversation? Yes No

Printed Name	Signature	Date
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School	School Phone
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School Address

RECORDS REQUEST

Message to Parents: Please sign this form and submit it to the administration office at your child's current school with the enclosed, pre-addressed envelope. With this authorization, records will be sent directly to Cedar River Academy.

Applicant Name: _____ Applying to Grade: _____

Parent/Guardian Signature Date

Message to Registrar: The above named applicant is applying for admission to Cedar River Academy.

Our Admissions Office requests the following information:

1. A copy of report cards from the current year.
2. Copies of report cards from previous two school years (if applicable).
3. Results of all standardized testing.

School Representative Signature Date

**CEDAR RIVER ACADEMY PARENT HANDBOOK
PARENT/GUARDIAN ACKNOWLEDGMENT**

Student Name: _____

I have received a copy of Cedar River Academy Parent Handbook that includes the Emergency and Disaster Preparedness Plan, Health Policy, Weapons Policy, Smoking Policy, Pesticide Policy, and Food Policy and am familiar with their terms and content.

Parent/Guardian Signature

Date