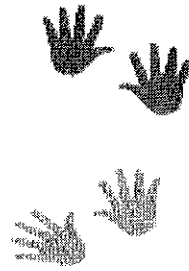


Discovery Charter School

Student Admissions Application 2009 – 2010



All applicants must be 5 years of age by September 1, 2009

APPLICATION DEADLINE IS MARCH 31ST

ALL APPLICANTS ARE SUBMITTED INTO A LOTTERY PROCESS FOR APRIL 2009.

What you must bring:

- Original Birth Certificate
- Original Social Security Card
- Updated Physical Exam
- Current Immunization Records
- Updated Dental Exam
- Proof of Residency (Utility Bill or Lease/Mortgage Agreement & Driver's License)
- Any IEP information (Special Education or Mentally Gifted)
- Small wallet size photo of child
- Current Report Card or Progress Report

NO INCOMPLETE APPLICATIONS WILL BE ACCEPTED





Student ID# _____
PASecure ID# _____

DISCOVERY CHARTER SCHOOL
5070 Parkside Avenue
Philadelphia, Pennsylvania 19131

**STUDENT ENROLLMENT NOTIFICATION FORM
FOR SCHOOL YEAR 2009-2010**

Charter School Contact Person: Pamela Evans

Telephone: 215-879-8182 Facsimile: 215-879-9510 E-Mail address: pam_evans_dcs@yahoo.com

Please print or type

I. STUDENT INFORMATION:

Last Name: _____ First Name: _____ MI _____

Home Address: _____

City/State/ Zip: _____

Telephone Numbers: Day (_____) _____ Evening (_____) _____ Cell (_____) _____

Mailing Address (if different from home address): _____

City/ State/ Zip: _____

Date of Birth: _____ Age: _____ Enrolling Grade _____

ALL APPLICANTS MUST BE 5 YEARS OF AGE BY SEPTEMBER 1, 2009.

II. SCHOOL DISTRICT OF RESIDENCE AND FORMER SCHOOL INFORMATION

School District of Residence: _____

Former School Information (other than pre-school):

____ Public School ____ Non-public School

Student not enrolled in any school prior to enrollment in Charter School because:

____ Charter School ____ Entering Kindergarten

____ Home School ____ Other

Former School: _____

Address of Former School: _____

Enrolling Grade: _____ Withdrawal Date from Former School: _____

Check here if this applicant is the sibling of a current student.

III. PARENT/GUARDIAN INFORMATION:

Child lives with:

Both Parents, Both Parents Alternately, Mother Only, Father Only, Legal Guardian, Foster Parent, Other Adult, Please state relationship

Special custodial court instructions: Yes No (if yes, please provide court order)

Complete parent/ guardian information as applicable

Father's Name:

Address:

City/ State/ Zip:

Telephone Numbers:

Home () Work : () Cell: ()

Email Address:

Mother's Name:

Address:

City/ State/ Zip:

Telephone Numbers:

Home () Work : () Cell: ()

Email Address:

(If student is not living with parents, please complete this section.)

Guardian Foster Parent Other Adult:

Name:

Address:

City/ State/ Zip:

Telephone Numbers:

Home () Work : () Cell: ()

Email Address:

My signature on this form indicates my decision to have my child attend Discovery Charter School.

Signature of Parent/Guardian Date:

IV. TO BE COMPLETED BY DISCOVERY CHARTER SCHOOL REPRESENTATIVE:

Verification of date of birth:

Birth Certificate, Other: Mortgage Statement, Lease, Utility Bill, Other:

Immunization Records:

Yes No Official Enrollment Date: Grade Student is Entering Grade: Anticipated Date of First Attendance:

Signature of Charter School Representative: Date:

V. SPECIAL ISSUES AND CONCERNS

A. EMERGENCY CONTACT INFORMATION

The following are the only authorized persons to pick-up, be contacted and/or interact with my child during the scheduled school hours. Any changes to this list must be submitted to the school in writing.

Name: _____ Relationship to student: _____

Address: _____

Home (____) _____ Work : (____) _____ Cell: (____) _____

Name: _____ Relationship to student: _____

Address: _____

Home (____) _____ Work : (____) _____ Cell: (____) _____

Name: _____ Relationship to student: _____

Address: _____

Home (____) _____ Work : (____) _____ Cell: (____) _____

B. MEDICAL CONCERNS

Does your child have special medical concerns? _____ Yes _____ No

If yes, please explain: _____

Child's Medical Provider: _____

Child's Primary Physician: _____

Physician's Office Address: _____

Physician's Phone Number: (____) _____

Consent to release information/records: _____ Yes _____ No

My signature below indicates that the information provided is true and any false information will void the enrollment of this student in the Discovery Charter School. I understand that completion of this application does not guarantee my child's enrollment. I acknowledge that this application is valid until December 31, 2008.

Parent Signature: _____ Date: _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____	DATE OF BIRTH _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F
Last _____	First _____	Middle _____

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code
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MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	DOSES				
	DOSES				BOOSTERS & DATES
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other _____					

- MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on _____ Date

Result of Diagnostic Studies: _____ Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. No Yes Date _____

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
⊙ Height (inches)				
⊙ Weight (pounds) BMI				
⊙ Pulse ()				
⊙ Blood Pressure /				
⊙ Hair/Scalp				
⊙ Skin				
⊙ Eyes/Vision				
⊙ Ears/Hearing				
⊙ Nose and Throat				
⊙ Teeth and Gingiva				
⊙ Lymph Glands				
⊙ Heart — Murmur, etc.				
⊙ Lung — Adventitious Findings				
⊙ Abdomen				
⊙ Genitourinary				
⊙ Neuromuscular System				
⊙ Extremities				
⊙ Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

Print Name of Examiner

Address

Telephone Number

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 20 ____

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		<input type="checkbox"/> M <input type="checkbox"/> F		
ADDRESS				
_____ No. and Street City or Post Office Borough or Township County State Zip				

REPORT OF EXAMINATION

		TOOTH CHART																								
		RIGHT								LEFT																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16									
UPPER					A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T		Upper
LOWER		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17									Lower
	UPPER																									Upper
	LOWER																									Lower

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address