

## Sonbeam Day School

Emory Baptist Church  
Pastor: Dr. Joe Perkins

Emory, TX 75440

Phone: (903) 473-3357  
Director: Phyllis Mikulak

**“Train up a child in the way he should go, and when he is old he will not depart from it.” Proverbs 22:6**

### **Sonbeam Day School Application PK3 and PK4 Christian-based program**

**All fees must be paid and all forms must be completed before your child begins classes.**

#### **Requirements for enrollment**

- Meeting with Director
- Supply fee \$75.00 one-time fee, non-refundable
- First month's tuition \$120.00 (one child), \*\$10.00 discount for each additional child in immediate family and living in same home.
- Completed application
  - Pledge of Acceptance signed
  - Health inventory completed
  - Immunization records (copy)
  - Birth certificate (copy) \*Must be 3 years old by September 1 of current school year to enroll in PK3; must be 4 years old by September 1 of current school year to enroll in PK4.
  - Emergency forms completed
  - Physician's statement completed/signed
  - Copy of legal custody documentation (as needed)

❖ **Tuition is due in full on the first school day of each month.**

❖ **Full tuition is due each month regardless of number of days attended.**

❖ **Sonbeam Day School is in session on Tuesdays and Thursdays**

❖ **School hours are 8:00 a.m. until 3:00 p.m.**

As a courtesy to our staff:

- Please bring students between 7:50-8:15 a.m.
  - Finish breakfast before coming to school
  - Keep toys and 'extras' at home
- Please pick up students between 2:45-3:15 p.m.
- Keep sick children home: children must be 24 hours free of fever, vomiting, and/or diarrhea before returning to school.

#### *Notice of Nondiscriminatory Policy*

*Sonbeam Day School does not discriminate on the basis of race, color, national, or ethnic origin in administrative policies, admissions policies, scholarships, and other school administered programs.*

Date \_\_\_\_\_

### Sonbeam Day School Student Application

Child's Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Age as of Sept. 1 this year \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Child's Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Age as of Sept. 1 this year \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Child's Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Age as of Sept. 1 this year \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home address \_\_\_\_\_ Home phone \_\_\_\_\_

Email \_\_\_\_\_

Father \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Mother \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Guardian \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Guardian \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

#### Other children in home

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Family Church \_\_\_\_\_

Is Father a Christian? \_\_\_\_\_

Is Mother a Christian? \_\_\_\_\_

Is Guardian a Christian? \_\_\_\_\_

**Health Inventory**

<b>Disease History</b>	<b>Age of Onset</b>	<b>On Medication</b>	<b>Disease History</b>	<b>Age of Onset</b>	<b>On Medication</b>
Asthma			Kidney Disorder		
Allergy			Rheumatic Fever		
Blood Disorder			Serious Accident		
Convulsions/Seizures			Surgery		
Diabetes			T.B. Contact		
Epilepsy			Hearing Loss		
Heart Disease			Vision Loss		
Fracture					

Is your child currently under treatment for any of the conditions listed above or any other medical conditions? \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there any physical or mental conditions that our staff should know about in order to better understand your child? \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Family/Child's Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Name of relatives or friends to contact if parents are not available in case of emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**ALLERGY ALERT**

**PLEASE INDICATE BELOW ANY ALLERGY INFORMATION WE NEED TO KNOW ABOUT YOUR CHILD.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Permissions and Authorizations**

I authorize Sonbeam Day School to release my child to:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to child \_\_\_\_\_

In the event I cannot be reached to make arrangements for emergency medical attention, I authorize Sonbeam Day School staff to contact the persons listed above, and the named physician, hospital and /or clinic to render such treatments deemed necessary for the welfare of my child. In the event the physician, persons named, or parents/guardians cannot be contacted, the SDS staff is authorized to take action necessary for the health and well-being of my child.

Family/Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Hospital/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

For your child's benefit, please list and describe any chronic health conditions or special needs. Also list any serious illness/injury during the last 12 months.

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Please list any medications prescribed for long-term continuous use:

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Parents/Guardians \_\_\_\_\_

Sonbeam Day School

PO Box 248  
260 Planters St.  
Emory, TX 75440

Phone: 903 473 3357  
Fax: 903 473 3932

**\*PHYSICIAN'S STATEMENT**

I have examined \_\_\_\_\_ within the past 12 months  
and find that he/she is physically able to take part in a pre-school program.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\* You may use this form or staple the form from your physician's office to this page.