

FIRST BAPTIST SCHOOL



Reach the Students. Glorify Christ. Transform the World.

APPLICATION PACKET

Then you will understand what is right, just, and fair,
... for wisdom will enter your heart, and
knowledge will fill you with joy.
Proverbs 2:9-10 NLV

Welcome to the First Baptist School Family

Thank you for your interest in First Baptist School. We know that you have many choices in education; therefore, we are delighted that you are entrusting us with this opportunity. Please know that we do not take this privilege lightly. Rest assured that our dedicated staff and faculty will do their utmost to ensure the success of your students. Your participation is welcomed and appreciated. Please read through this packet carefully and completely. Complete information will greatly enhance our ability to be effective. As we trust in the Lord, we are looking forward to serving you and your family.

Serving Him,
Terry A. Roberts
Superintendent

Admissions Checklist:

- ✓ Completed application form
- ✓ Up-to-date immunization record (see physical form for more info)
- ✓ Birth Certificate
- ✓ Social Security Card
- ✓ Report Cards (previous 2 years)
- ✓ Standardized Test Scores (Iowa or Stanford)
- ✓ Pastor Recommendation Letter (**Secondary students only, 6th-12th**)
- ✓ Current Teacher/Administrator Reference Letter (**Secondary students only, 6th-12th**)

Once the application is complete and submitted to the school office, an appointment will be made for the student to be tested. After testing, the office will call the parents to schedule an interview with the school principal. Both parents, as well as the students, need to attend the interview. FBS looks at a variety of factors when determining acceptance to our school. These factors include personal motivation, past scholastic performance, and test results. Following the interview, the family will be notified of the acceptance decision. The family will then have two weeks to respond to the decision and complete the enrollment procedures.

If you have any questions or need assistance during this process, please contact the school office at (956) 542-4854.

FIRST BAPTIST SCHOOL RESERVES THE RIGHT TO REQUEST THE WITHDRAWAL OF ANY STUDENT WHO DOES NOT MEET ACADEMIC REQUIREMENTS OR FAILS TO CONFORM TO ITS RULES AND POLICIES.

First Baptist School is fully accredited by the Association of Christian Schools International (ACSI) and does not discriminate on the basis of race, national or ethnic origin, gender, age or disability in its admissions policies or access to its educational, and extracurricular programs and activities.

First Baptist School is committed to glorifying God by providing a biblically based education so that students are transformed and equipped to meet the challenges of post-secondary education and career advancement, while serving and impacting the world for the Kingdom of Christ.



ENROLLMENT APPLICATION

2026-2027

Date of Application: _____
Grade: _____ Fall / Spring
School Year: 20____ - 20____

STUDENT'S FULL LEGAL NAME: _____ Male ___ Female ___
Last First Middle
Home/Mailing address: _____ Date of Birth: _____
Street/PO Box Month Day Year
City State Zip SS or ID number: _____
Phone Number: (____) _____ Citizenship: ___ U.S ___ Mexico Other _____
Ethnicity: _____

Father's Name: _____
Address _____
Street
City State Zip
Home Phone No. (____) _____
Cell Phone No. (____) _____
E-mail _____
Occupation/Title _____
Name of Business _____
Address _____
Street
City State Zip
Work Phone No. _____
Fax No. _____
Other contact _____

Mother's Name: _____
Address _____
Street
City State Zip
Home Phone No. (____) _____
Cell Phone No. (____) _____
E-mail _____
Occupation/Title _____
Name of Business _____
Address _____
Street
City State Zip
Work Phone No. _____
Fax No. _____
Other contact _____

WILL THE APPLICANT BE ATTENDING EXTENDED CARE SERVICES*? ___ Yes ___ No
___ Before School (7:30-8:00 am) ___ After School (4:00 - 5:15)
***All elementary students arriving before 8:00 am and/or remaining after 4:00 are required to be in Extended Care**

Please choose a tuition payment plan.
___ Annual Payment (\$200 discount for families who pay tuition and fees by July 31, 2026)
___ 10 month payment plan (August thru May) (First payment is due on August 1, 2026)
All books and fees due before July 1, 2026

Family referred by _____

For Official Use Only Family ID# _____
Application Fee ___ CRD Cash Chk # ___ Testing Req: Yes ___ No ___ Testing Fee: ___ CRD Cash Chk # ___
Interview Date: _____ Accepted Yes ___ No ___ Registration Fee _____ CRD Cash Chk # _____

SIBLINGS

Name _____ Grade _____ School _____

Name _____ Grade _____ School _____

Church of Regular Attendance _____

SCHOOL HISTORY

Present School _____ Principal _____ Phone (____) _____

Address _____

Street _____ City _____ State _____ Zip _____

Former School/Daycare _____ Grades Attended _____ Phone (____) _____

Address _____

Street _____ City _____ State _____ Zip _____

Is the applicant changing schools: Voluntarily _____ Involuntarily _____

If involuntarily, please explain:

ACADEMIC HISTORY

Has the applicant ever skipped or repeated a grade? Yes _____ No _____

If yes, please explain:

Has the applicant ever consulted with a professional for testing or guidance? Yes _____ No _____

If yes, was this testing for

_____ Speech/Language Development _____ ADD/ADHD

_____ Counseling _____ Learning Difference

_____ Other, please specify _____

If Yes, please attach a copy of all test reports.

Describe any special circumstances that have affected the applicant's prior performance in school.

I certify that the information given on this application is factual and true. I understand that falsifying information contained in this application may be cause for immediate dismissal.

Father's signature _____ Date _____

Mother's signature _____ Date _____

Legal Guardian's Signature _____ Date _____



STUDENT INFORMATION AND EMERGENCY MEDICAL FORM

Student's Name _____ Date of Birth _____ Grade _____

In the event that I/we cannot be reached to make arrangements for emergency medical attention, the administration/faculty of First Baptist School should contact the persons listed below who have authorization to secure medical attention for my child. In the unlikely event that these persons are unavailable, I/we authorize the school personnel to contact the licensed physician listed below for medical advice and, if necessary, to transport my child to the physician's office or whatever medical treatment facility s/he recommends. In the event the physician is unavailable or unwilling to give direction to the school personnel, they also have my/our authorization to use their professional discretion to secure the best available medical attention for my child.

First Baptist School DOES NOT ASSUME any responsibility in case of accident or injury. I do hereby agree to indemnify and hold harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of this student. If between this date and the beginning of school any illness or injury should occur that might limit this student's participation in any activities, or if there is a change in status during the school year, I agree to notify the school authorities.

At least one emergency contact, in addition to the parents, is required for each student.

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL

MEDICAL FACILITY/PERSONNEL

Physician's name _____ Phone: () _____

Address _____

City

Other preferred medical treatment facility or contact: _____ Phone () _____

Address _____

City

Special medical information/instructions or comments:

MAJOR MEDICAL INSURANCE INFORMATION

Company _____ Policy Holder: _____

Policy # _____ Group # _____ Phone _____

ALLERGIES Please circle any which apply to your child:

PENICILLIN ASTHMA/HAY FEVER SUNBURN SENSITIVITY INSECTS OTHER: _____

Treatment procedures, should the child display an allergic reaction:

OTHER INFORMATION

At times, students complain of common discomforts – headaches, sore throats or stomach aches. **Please circle which items the school may** administer to your child. *Without your permission these medications will not be administered.*

Tylenol Cough Drop Antacid Tablet

Does your child wear: Glasses _____ Contact Lenses: _____ Hearing Aids _____

PICK-UP INFORMATION: The following may take this student from school:

NAME	RELATIONSHIP	PARENT INITIALS

To the best of my knowledge, the information provided above and on the previous pages is true and accurate.

FATHER: _____

DATE: _____

MOTHER: _____

DATE: _____

LEGAL GUARDIAN/S: _____

DATE: _____



CONTRACTUAL AGREEMENT

STUDENT'S NAME: _____ GRADE: ____ SCHOOL YEAR 20__ - 20__

FINANCIAL AGREEMENT

I understand that...

Payments are to be made on a 10-month (Aug. – May) plan, unless annual or semi-annual payment arrangements are made. Payments are due on the 1st of each month and are considered delinquent after the 10th. Fees are due by July 1 and considered late on the 10th. **At that time, a 10% late fee will be added to the balance of my account.**

If my first payment is not made by August 10th, my student's name may be replaced by someone on the waiting list.

First Baptist School does not issue refunds on registration fees or on the initial June and August payment.

If my account is delinquent and prior arrangements have not been made with the administration, my student will not be allowed to participate in any extracurricular activities until tuition is paid and may be subject to removal from the school.

REPORT CARDS will not be issued until all accounts are paid in full.

PARTICIPATION AGREEMENT

My student has permission to participate in all school activities, including bus trips, sports activities, and school-sponsored trips away from the school premises. I also grant permission to FBS and its staff to photograph, videotape, or audiotape my student and to copyright, use and/or publish the photographs/videotapes and audiotapes in any school publication and public relations related material.

We agree to attend the parent meetings during the school year, as well as Open House or Parent Conferences.

STATEMENT OF COOPERATION

I agree that if my student is enrolled at First Baptist School, I will do my utmost to cooperate with and support the school in its methods and principles of education. I have read the Parent-Student Handbook and agree to support the policies therein.

SIGNATURES: BOTH PARENTS MUST SIGN

FATHER: _____ DATE: _____

MOTHER: _____ DATE: _____

LEGAL GUARDIAN/S: _____ DATE: _____



Federal Programs Qualification Form 2026-2027

This form must be completed and included with all registration packets

The Brownsville Independent School District Federal Programs welcomes the opportunity to assist and support First Baptist School with additional reading and math labs. In order to determine whether or not your student is eligible, please complete the following survey. Find your family size and look at the annual gross income level beside it on the chart printed below.

<i>HOUSEHOLD SIZE</i>	<i>ANNUAL INCOME</i>
1	23,107
2	31,284
3	39,461
4	47,368
5	55,815
6	63,992
7	72,169
8	80,346

Is your family income less than the amount on the chart? _____ yes _____ no

Student Name: _____

Address: _____

Public School your student is zoned for with BISD: _____

Grade level of your student: _____

PLEASE INDICATE ONLY ONE LANGUAGE PER RESPONSE:

1. What language is used in the students' home **most of the time**? _____
2. What language does the student use **most of the time**? _____

Parent/Guardian signature: _____ Date: _____

Grade 9th – 12th Student Signature: _____ Date: _____



First Baptist School Physical Examination Form

Year _____

Grade: _____

Both sides of this form must be completed and on file prior to participation in any athletic activity, including P.E. and recess.

Student's Name _____ Gender _____ Age _____ Date of Birth _____
 Height _____ Weight _____ Pulse _____ Blood Pressure _____

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/ears/nose/throat			
Lymph nodes			
Heart – auscultation of the heart in the supine position			
- auscultation of the heart in the standing position			
- pulses (all extremities)			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
foot			

Station-based examination only

Medical History Questionnaire - to be completed by the physician

- | | | | |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. | Is the patient under a doctor's care for a specific medical condition? | Yes | No |
| 2. | Has the patient been hospitalized overnight in the past year? | Yes | No |
| 3. | Has the patient had surgery in the past year? | Yes | No |
| 4. | Is the patient currently taking any prescription or over-the-counter medications? | Yes | No |
| 5. | Has the patient ever experienced any complications during or after exercise? | Yes | No |
| 6. | Does the patient cough, wheeze, or have trouble breathing during exercise? | Yes | No |
| 7. | Does the patient have asthma? Yes No Does the patient use an inhaler? | Yes | No |
| 8. | Has the patient ever been treated for high blood pressure or high cholesterol? | Yes | No |
| 9. | Does the patient have a heart murmur? | Yes | No |
| 10. | Has a doctor ever denied or restricted participation in sports due to heart or other problem? | Yes | No |
| 11. | Has the patient had a severe viral infection (e.g.; myocarditis or mononucleosis) within the last year? | Yes | No |
| 12. | Has the patient ever had a head injury or concussion? | Yes | No |
| 13. | Has the patient ever been knocked out, become unconscious, or lost their memory? | Yes | No |
| 14. | Has the patient ever had a seizure? | Yes | No |
| 15. | Is the patient missing any organs? | Yes | No |
| 16. | Does the patient use any special protective or corrective equipment or devices (e.g.; knee brace, oral retainer, foot orthotics, neck support) | Yes | No |
| 17. | Has the patient ever experienced a ligament sprain, muscle strain or swelling in the joints due to injury? | Yes | No |
| 18. | Has the patient ever broken or fractured a bone or dislocated any joints? | Yes | No |
| 19. | Has the patient had any other problems with pain or swelling in muscles, tendons, bones or joints? | Yes | No |

Please provide explanations to "yes" responses:

HEARING @ 25 dB Date: _____ Screener Name: _____ Signature: _____
(Pure-Tone audiometric Sweep-Check Screen)
HZ _____ 1000 2000 4000
Right _____
Left _____ Pass _____ Fail _____

Vision and Hearing: *Required of incoming 1st, 3rd, 5th, 7th graders and **ALL NEW STUDENTS***

VISION Date: _____ Screener Name: _____ Signature: _____
Right 20/ _____ Left 20/ _____ Pass _____ Fail _____

SPINAL Date: _____ Screener Name: _____ Signature: _____
L R
___ ___ High Shoulder
___ ___ Shoulder blade stands out more than the other
___ ___ Obvious curve of the spine in area rib cage
___ ___ Rib hump
___ ___ Obvious curve of spine in lower back
___ ___ Hip higher than the other side
Other (including round back): _____
Diagnosis: _____
Recommendation:
___ No Treatment
___ Treatment: ___ Observation ___ Brace ___ Surgery
___ Other (describe): _____
___ Referral (describe): _____
Activity Limitation (if any): _____
Additional Comments: _____
Return Appointment and Date, if any: _____

Required of all incoming 5th – 9th graders only

Acanthosis Nigricans Date: _____ Screener Name: _____ Signature: _____
AN Marker present (from palpation of Neck)? ___ Yes ___ No
If Yes, please record child's:
DOB: _____ Sex: ___ (M/F) Ethnicity: _____
Height (inches): _____ Weight (lbs): _____ BMI: _____
Blood Pressure (two, 3-5 minutes rest between): _____
___ Normal (below 90th %) ___ Pre-hypertension (90-95th %) ___ Hypertension (95th % or more)

*Required of incoming 1st, 3rd, 5th, 7th graders and **ALL NEW STUDENTS***

Chickenpox (Varicella) Date: _____ Name: _____ Signature: _____
This is to verify that the above student had the varicella (chickenpox) illness on or about the following date (_____) and does not need the vaccine.

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Statement of Clearance

I have examined this student and completed the questionnaire with the patient or legal guardian and have considered their responses in my statement of clearance for participation in physical activities.

I, hereby, certify that this student is:

___ cleared for all physical activities

___ cleared, after completing evaluation/rehabilitation for _____

___ not cleared for _____ Reason: _____
(State specific activity/activities)

This form must be **completed and signed** by a Physician, a licensed Physician Assistant or a Nurse Practitioner. Examination forms signed by any other health care practitioner, including chiropractors, will not be accepted.

Examiner's name _____ Phone Number _____
Address _____
Street City State Zip
Signature _____ Date of Examination _____



PASTOR'S RECOMMENDATION

Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN BEFORE GIVING TO YOUR PASTOR

Parent/Guardian Name(s) _____

_____ Street Address City State Zip Code

School(s) applying for:

___ Elementary School ___ Middle School ___ High School

Name(s) of student(s) applying for admission:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

TO BE COMPLETED BY THE PASTOR

The above family is applying for admission to the First Baptist School. Please answer the following questions and mail the completed form to First Baptist School. Thank you.

Does your church support the philosophy statement on the reverse of this form? ___ Yes ___ No
Is this family a member of your church? ___ Yes ___ No
Does this family attend worship services at your church regularly? ___ Yes ___ No

Are there any other matters that you feel would be helpful for us to know regarding this family? _____

_____ Pastor's Name Pastor's Signature

_____ Name of Church Pastor's E-mail

(_____) _____ (_____) _____
Telephone Fax

_____ Church Address

_____ City State ZIP Code

FBS does not discriminate on the basis of race, color, national or ethnic origin in its admissions policies or access to its educational and extra-curricular programs and activities.

**PLEASE MAIL THIS RECOMMENDATION TO THE ADDRESS GIVEN BELOW,
OR RETURN TO THE APPLICANT IN A SEALED ENVELOPE WHICH YOU HAVE SIGNED OVER THE SEAL.**

FIRST BAPTIST SCHOOL STATEMENT OF FAITH

We believe and unqualifiedly affirm:

- *The inspiration of the Bible, equally in all parts and without error in its origin.
- *The one God, eternally existent Father, Son and Holy Spirit, who created man by a direct immediate act.
- *The pre-existence, incarnation, virgin birth, sinless life, miracles, substitutionary death, bodily resurrection, ascension to Heaven, and the second coming of the Lord Jesus Christ.
- *The fall of man, the need of regeneration by the operation of the Holy Spirit on the basis of grace alone, and the resurrection of all to life or damnation.
- *The spiritual relationship of all believers in the Lord Jesus Christ, living a life of righteous works, separated from the world, witnessing of His saving grace through the ministry of the Holy Spirit.



TEACHER REFERRAL FORM

APPLICANT'S NAME _____

The above applicant desires to be a student at First Baptist School and wishes to use your name as a reference. FBS accepts students who have a commitment to Christian excellence and who will support the principles and policies of FBS. This referral will be kept strictly confidential. We appreciate your time in providing us with your honest appraisal of this applicant.

How long have you known the applicant? _____(yrs.)

What, in your estimation, are the applicant's strengths?

In what areas might the applicant need to experience growth?

IF THERE IS ADDITIONAL INFORMATION ABOUT THIS APPLICANT THAT YOU FEEL WE SHOULD KNOW PLEASE INDICATE ON THE BACK OF THIS FORM.

On the following scale, with 1 being the weakest and 5 being the strongest, please share your personal appraisal of the applicant.

A. Spirituality	1	2	3	4	5	don't know
B. Intellect	1	2	3	4	5	don't know
C. Judgment	1	2	3	4	5	don't know
D. Attitude	1	2	3	4	5	don't know
E. Relationship to church	1	2	3	4	5	don't know
F. Lifestyle	1	2	3	4	5	don't know
G. Personal discipline	1	2	3	4	5	don't know

- I recommend this applicant without reservation.
- I recommend this applicant with reservation.
- I do not recommend this applicant under the present circumstances.
- I do not recommend this applicant under any circumstances.

Your name _____ Position _____
Address _____ Phone _____

May we contact you by phone concerning this applicant? yes no

**PLEASE MAIL THIS RECOMMENDATION TO THE ADDRESS GIVEN BELOW,
OR RETURN TO THE APPLICANT IN A SEALED ENVELOPE WHICH YOU HAVE SIGNED OVER THE SEAL.**

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Principal's Evaluation Form

Student Full Name _____

DOB: _____ Grade Level _____

Yes ___ No ___ Is your school accredited?

Yes ___ No ___ Is the student eligible to re-enter your school next term?

Yes ___ No ___ Is the student currently in a Special Education Program?

Yes ___ No ___ Has the student been involved in acts of dishonesty?

Yes ___ No ___ Has the student been involved in substance abuse this year?

Yes ___ No ___ Has the student participated in or stimulated disorderly, disruptive, or unmannerly conduct?

Yes ___ No ___ Has the student exhibited unsatisfactory adjustments to other students?

Yes ___ No ___ Has the student had physical health problems?

Yes ___ No ___ Has the student had emotional health problems?

Yes ___ No ___ Has the student been disciplined by administrators?

Yes ___ No ___ Has the student been suspended?

Yes ___ No ___ Has the student been expelled?

Yes ___ No ___ Has this student exhibited any behavior that would indicate a(probability) (possibility) (danger) that he (will) (could) (might) abuse or assault a fellow student?

Yes ___ No ___ Has this student made any statements or threats that would indicate risk or harm towards others?

Please give us your candid opinion of this student as a student and citizen. We wish to know about the student's work habits, motivation, sense of humor, areas of strength and areas of weakness. We are particularly interested in your estimate of this student's potential. If there are any reasons why you would NOT recommend this applicant as a student, please share those thoughts with us as well. Thank you for your time and cooperation. *Please attach your explanation.*

Name of person completing this form

First Name _____ Last Name _____

Signature _____ Title _____

Date _____

Name of School _____

Address

City

State

ZC