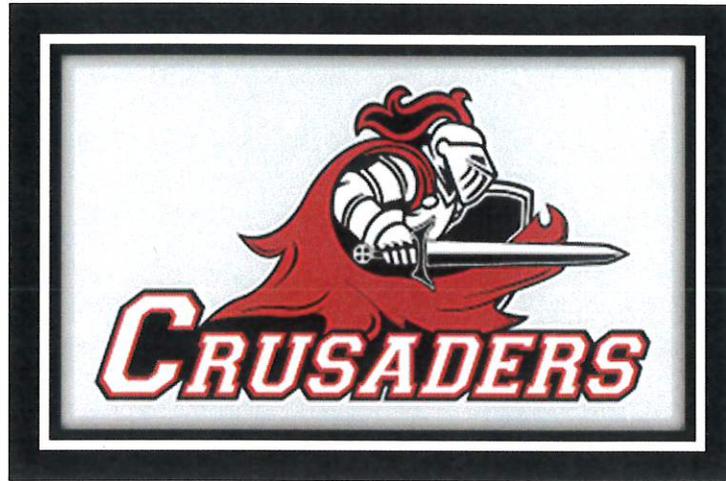


# FIRST BAPTIST SCHOOL



*Reach the Students. Glorify Christ. Transform the World.*

## RE-ENROLLMENT 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

## ***First Baptist School Family***

Thank you for your continued interest in First Baptist School. We know that you have many choices for the education of your children; therefore, we are delighted that you are entrusting us with this opportunity. 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 crucial. As we trust in the Lord, we are looking forward to serving you and your family.

Please fill out your application completely. Only completed applications with updated immunization records will be processed.

Good communication will greatly enhance our ability to be effective. Our primary and official source of communication is by e-mail. Therefore, each family is required to have a current e-mail address on file in the school office. I would encourage you to ensure that you maintain current email and cell phone numbers with the school as they are also used in case of emergency.

We are here to serve you and consider it a joy and a privilege to do so. However, volunteers play a vital role in the success of our school. Our army of volunteers helps to keep tuition low and puts "icing" on the cake. Let the school office know if you are interested in this wonderful opportunity.

We pray that God will bless you and your family.

Serving Him,

*Terry A. Roberts*  
Superintendent

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.

**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 based on race, national or ethnic origin, gender, age or disability in its admissions policies or access to its educational, and extracurricular programs and activities.



# RE-ENROLLMENT APPLICATION 2026-2027

Date of Application: \_\_\_\_\_  
 Student is applying for: \_\_\_\_\_ Grade.  
 School year: 20\_\_ - 20\_\_

**STUDENT'S FULL LEGAL NAME:** \_\_\_\_\_  
 Last First Middle Called  
 Home/Mailing address: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
 Street/PO Box  
 Student's email address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**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 \_\_\_\_\_

**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*

**WILL THE STUDENT BE ATTENDING EXTENDED CARE SERVICES\*?** \_\_\_\_\_ Yes \_\_\_\_\_ No  
 \_\_\_\_\_ Before School (7:30-8:00 am) \_\_\_\_\_ After School (4:00 - 5:15 pm)  
 \*ALL ELEMENTARY STUDENTS ARRIVING BEFORE 8:00 AM AND/OR REMAINING AFTER 4:00 PM ARE REQUIRED TO BE IN EXTENDED CARE

For Office Use Only      FACTS # \_\_\_\_\_  
 Re-enrollment Fee \_\_\_\_\_      Cash or Check # \_\_\_\_\_      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 student. 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 student 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 student.

**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 State Zip

Other preferred medical treatment facility or contact: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Special medical information/instructions or comments:  
\_\_\_\_\_  
\_\_\_\_\_

### MAJOR MEDICAL INSURANCE INFORMATION

Company \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

**ALLERGIES** Please circle any which apply to your student:  
PENICILLIN ASTHMA/HAY FEVER SUNBURN SENSITIVITY INSECTS OTHER: \_\_\_\_\_

**TREATMENT PROCEDURES, SHOULD THE STUDENT 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 student.** 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 pick this student up 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's signature \_\_\_\_\_ Date \_\_\_\_\_

Mother's signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



# CONTRACTUAL AGREEMENT

SCHOOL YEAR 20\_\_ - 20\_\_

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

## 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 1<sup>st</sup> of each month and are considered delinquent after the 10<sup>th</sup>. Fees are due by July 1 and considered late on the 10<sup>th</sup>.

**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 10<sup>th</sup>, my student's name may be replaced by someone on the waiting list.

First Baptist School does not issue refunds on registration fees or initial tuition **payments**.

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 my student is subject to removal from the school.

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

## PARTICIPATION AGREEMENT

My child 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 me, my student/ ward and to copyright, use and/or publish the photographs/videotapes and audiotapes in any school publication or 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

**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 \_\_\_\_\_



### Federal Programs Qualification Form 2026-2027

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.

HOUSEHOLD SIZE	ANNUAL INCOME
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

Please provide the following information:

Name of student (s): \_\_\_\_\_

Address: \_\_\_\_\_

Public School your student (s) is zoned for with BISD: \_\_\_\_\_

Grade Levels of your student (s): \_\_\_\_\_

**NOTE: 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**? \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student if **Grades 9-12**: \_\_\_\_\_ Date: \_\_\_\_\_



# First Baptist School Physical Examination Form

Year: \_\_\_\_\_

Grade: \_\_\_\_\_

Both sides of this form must be completed, and turned into the school office before your student is allowed to participate 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
<b>Appearance</b>			
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 problems or other problems?   | 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 ALL incoming 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 7<sup>th</sup> grade students **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 ONLY** of ALL incoming 5<sup>th</sup> – 9<sup>th</sup> grade students,

**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 90<sup>th</sup> %) \_\_\_ Pre-hypertension (90-95<sup>th</sup> %) \_\_\_ Hypertension (95<sup>th</sup> % or more)

**REQUIRED** of ALL incoming 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 7<sup>th</sup> grade students **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.

**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 \_\_\_\_\_