



Academy Application (Please fill out completely)

School Code: **3946**

Academic Year _____

Date _____

Child/Family Information

Child's Full Name _____

DOB _____ SSN _____ Gender: Male Female

Address _____

County _____ Phone _____

Responsible for Fee Payment _____

Parent/Guardian Name _____ Relation to Child _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Occupation _____

Parent/Guardian Name _____ Relation to Child _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Occupation _____

Grandparent Name(s) _____

Address _____

Phone _____ Email _____

Grandparent Name(s) _____

Address _____

Phone _____ Email _____

Grandparent Name(s) _____

Address _____

Phone _____ Email _____

Grandparent Name(s) _____

Address _____

Phone _____ Email _____

The following information is for grant reporting purposes only and will be kept strictly confidential.

QuestKids does not discriminate on the basis of race, gender, religion, national origin or family income.

Household Type:

- Married/Couple
- Single Female
- Single Male
- Extended/Multi-Family
- Legal Guardian/Other

Race/Ethnicity:

- African-American
- Asian/Pacific Islander
- Caucasian
- Hispanic/Latino
- Indian Sub-Continent
- Multi-Racial
- Native American
- Other

Household Income:

- Less Than \$10,000
- \$10,000 - \$14,999
- \$15,000 - \$19,999
- \$20,000 - \$29,999
- \$30,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 - \$99,999
- More Than \$100,000

Number of People in Household:

Children: _____ Male _____ Female

Adults: _____ Male _____ Female

Total _____

Medical Information

Doctor's Name _____ Phone _____

Address _____

List any information regarding the child's gestation and delivery (i.e. premature birth, complications): _____

List any medical or psychological diagnoses:

_____ Date _____
_____ Date _____
_____ Date _____

List any medications the child is currently taking. Attach a separate piece of paper if you need more space.

Medication(s)	Dosage	Date Prescribed	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any hospitalizations, surgeries or other medical illness:

_____ Date _____
_____ Date _____
_____ Date _____

List any allergies your child may have to food, medication or environment: _____

- | No | Yes | Does/is the child: |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Require the use of an EpiPen? |
| <input type="radio"/> | <input type="radio"/> | On a special diet?
If yes , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Refuse food?
If yes , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Weight range within normal limits?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Vision within normal limits?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Hearing within normal limits?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Ambulatory (able to walk without assistance)?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Able to make gross motor movement typical for their age?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Able to make fine motor movement typical for their age?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Have full range of motion in their arms and legs?
If no , please explain _____ |
| <input type="radio"/> | <input type="radio"/> | Have full use of their hands and fingers?
If no , please explain _____ |

Authorization

I certify that the information in this application is complete and accurate.

Parent/Guardian Signature

Date

Mail or fax completed application by June 19, 2009 to:

QuestKids
P.O. Box 531125
Orlando, FL 32853
407.218.4303