

INTERNATIONAL VISITOR REQUIRED DOCUMENTATION

The following documents must be submitted to our school office in order to complete the visitor registration process.

- Visitor Application** (School form)
- International Visitor Emergency Card** (School form)
- Passport** (Copy)
- Immunization Records** (Translated & Certified)
- Visitor Program Fee** (Due with application. Non-refundable.)

HEIGHTS CHRISTIAN SCHOOLS

LA MIRADA CAMPUS

12200 Oxford Drive, La Mirada, CA 90638
(562) 902-1779 • e-mail: office@lamiradaheights.org
(562) 902-1769 • www.lamiradaheights.org

OFFICE USE ONLY		
Date Received:	Amount:\$	
Ck#	Cash	Credit

INTERNATIONAL VISITATION PROGRAM 2011-2012

VISITOR APPLICATION

NOTE: Visitors are not issued I-20s and do not receive school credit

Visitor (Child) Information

Full Name _____ Grade _____ Birthday _____

U.S.A Street Address _____ City _____ Zip Code _____

U.S.A Home Telephone _____ American Name (if any) _____

Parent/Legal Guardian Information

1. _____
Father's Full Name _____ Work Phone# _____

_____ Email _____ Cell Phone# _____

2. _____
Mother's Full Name _____ Work Phone# _____

_____ Email _____ Cell Phone# _____

3. _____
Guardian Name _____ Work Phone# _____

_____ Email _____ Cell Phone# _____

English Speaking Contact:

Name: _____ Phone: _____ Email: _____

Date of Visit:

What dates will your child be visiting our school? (two-month limit per flat-rate fee)

_____ Start Date _____ End Date _____

Extended Day Care is available for an additional fee. Will you be using Extended Day Care? **Yes** **No**

MORE ON REVERSE SIDE

ACADEMIC PROGRAM (8:30AM-3:00PM)

VISITATION PROGRAM FEE: **\$2549.00** FLAT RATE FOR UP TO TWO MONTHS – DUE WITH APPLICATION; NON-REFUNDABLE

DAY CARE

EXTENDED DAY CARE: **MORNING:** 6:30-8:00AM **AFTERNOON:** 3:00-4:30PM **LATE AFTERNOON:** 3:00-6:00PM
Please contact the school office for pricing.

HOLIDAY DAY CARE: **\$15.00** PER DAY
Martin Luther King's Birthday, Veteran's Day, Teacher In-Service days, Teacher Conference days, half-days, Easter Break, Christmas Break (first week).

EMERGENCY DAY CARE: **\$5.00** PER HOUR
Available only during Extended Day Care hours. Limited to 5 uses per visitation stay.

PROGRAM FEES

- ◆ Visitation fee is a flat rate for up to a two-month stay.
- ◆ Visitation fee must be paid in U.S. currency.
- ◆ Visitation fee must be paid up-front and in-full.
- ◆ Visitation fee is non-refundable.
- ◆ Visitation fee includes office records and processing, consumable supplies, textbook usage, activities fees, and special accommodations.
- ◆ Extended Day Care is available for an additional fee.
- ◆ Any additional fees are due on the 1st of the month. A late fee of \$25 will be applied to the visitors' account for any account balance not paid by the 5th of the month.

CAMPUS HOURS

- ◆ The campus playground opens at 8:00AM. All students should report to the playground upon arrival. Students should not be dropped off any earlier than 8:00AM unless enrolled in the morning Extended Day Care program.
- ◆ The campus and school office are closed on the following holidays: Presidents' Day, Memorial Day, Labor Day, Thanksgiving (Thursday and Friday), and Christmas break (second week: Dec. 24th @ 1:00 PM to Jan. 1st). There is no Holiday Day Care available on these days.

BEHAVIOR

- ◆ My child and I agree to accept the responsibility of obeying the rules and regulations by which the school is operated, and to support the Christian principles for which it stands.
- ◆ I understand that violation of school standards by me or my child in some cases may constitute grounds for dismissal from our Visitation Program. Violations include but are not limited to: disciplinary issues, reckless or dangerous behavior, non-cooperation with staff, verbal or physical abuse of staff or students, harassment of school staff by a parent, philosophical differences with the values of Family Resource Ministries.

REQUIRED DOCUMENTS

- ◆ A copy of the student **passport** and **immunization records** must be submitted with this application.

I, the undersigned, understand and agree to the above conditions:

Signature of Parent/Legal Guardian

Date



WE ACCEPT VISA, MASTERCARD, AND DISCOVER

Payments can be made with credit card, debit card, or e-check via our website.
Payments can also be made with cash, personal check, or money order in the school office.

Non-Discrimination Policy: Heights Christian Schools admits students of any race, color, national or ethnic origin to all rights, privileges, programs and activities generally accorded to and/or available to students at school.

Heights Christian Schools is an affiliate of  Family Resource Ministries

International Visitor Emergency Card – Year 2011 - 2012

Heights Christian Schools - La Mirada Campus • 12200 Oxford Drive, La Mirada, CA 90638 • 562-902-1779

Student's Name: Last		First	Middle	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Grade:
Student lives in the USA with (check all that apply): <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Host Family						
Full Name of Father/Guardian:		Full Name of Mother:		American Name (if any):		
Host Address (street, city, zip)			Foreign Home Address		Providence/Territory	
			City		Country	
			Postal Code			
USA Home Phone ()	USA Work Phone ()	ext.		Foreign Home Phone ()	Foreign Work Phone ()	ext.
USA Cell Phone ()	USA Home Email		Foreign Cell Phone ()		Foreign Home Email	
USA Job Title	USA Work Email		Foreign Job Title		Foreign Work Email	
USA Employer			Foreign Employer			
USA Employer Address (street, city, zip)			Foreign Employer Address			
ENGLISH SPEAKING CONTACT PERSON						
NAME: _____ PHONE NUMBER: _____ EMAIL: _____						
Persons (18 years or older) authorized to pick up your child or to be contacted if unable to reach parents:						
1.Name	Address, City, State, Zip			Phone ()	Relationship	
2.Name	Address, City, State, Zip			Phone ()	Relationship	
3.Name	Address, City, State, Zip			Phone ()	Relationship	
4.Name	Address, City, State, Zip			Phone ()	Relationship	
5.Name of person outside California	Address, City, State, Zip			Phone ()	Relationship	
Name of your child's physician:				Phone ()		
In case of illness or accident, I hereby authorize school officials to call any local physician if none of the above persons can be reached.						

Authorization of Emergency Medical Treatment

I (we) the undersigned parent(s) or legal guardian of _____ a minor, do hereby authorize and consent to any emergency x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the medicine practice act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

List any physical restrictions	
Allergies to drugs or foods Allergic to bee stings? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any special medications or pertinent information	
Last Tetanus Toxide Booster	Financial Responsibility
Insurance Company	Policy Number
Date	Signature of Father/Guardian
Date	Signature of Mother

MORE ON REVERSE SIDE →

CONFIDENTIAL MEDICAL INFORMATION

Describe any significant accidents or surgeries that would limit the student's activities on campus:

Describe any known disabilities in vision, hearing or speech:

Describe any known disabilities emotionally, psychologically, or physically:

Prescription medications needed during school hours on an ON-GOING BASIS (including inhalers):

PRESCRIPTION MEDICATIONS (*Physician Signature Required*)

Medication Name	Amount/Frequency	Reason for Medication
Physician Name: _____ Physician Signature: _____		

Non-prescription medications needed during school hours on an ON-GOING BASIS:

NON-PRESCRIPTION MEDICATIONS

Medication Name	Amount/Frequency	Reason for Medication

NOTE: All prescription and non-prescription medication should be in its original container with printed directions on the label, and the student name clearly written on the container.

California Education Code Section, 49423 allows designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school, to maintain, or improve his/her potential for education and learning. However, this is a service or accommodation that the school is not legally required to perform. This is to be recognized by all parties signing this form, and in so signing, they agree to hold the school or its personnel free from any or all suits that might arise out of these arrangements.

I, _____, the parent/guardian of _____, request that the staff at **HCS-La Mirada Campus** administer the medication(s) as described above to my child in accordance with my written instructions above. I will notify the school immediately if there are any changes in medication or physicians.

Parent/Guardian Name: _____ Signature: _____