Cornerstone
CHRISTIAN ACADEMY
FOR LEARNING & LEADERSHIP

INTERNATIONAL STUDENT ACADEMIC AND CULTURAL STUDY PROGRAMS ~ APPLICATION FOR ADMISSION

Photo Here

STUDENT INFORMATION

Family Name _____ First _____ Middle _____ Nickname _____

Address _____

City _____ Country _____ Postal Code _____

Phone _____ Student E-mail _____ Fax _____

Date of Birth (Month/Day/Year) _____ Place of Birth _____

Citizenship _____

PARENT INFORMATION

Family Name _____ Father _____ Mother _____

Address _____

City _____ Country _____ Postal Code _____

Phone _____ Parent E-mail _____ Fax _____

Fathers Occupation and Title _____ Business/Firm _____

Father Business Address _____

Father Business Phone _____ Fax _____

Mother Occupation and Title _____ Business/Firm _____

Mother Business Address _____

Mother Business Phone _____ Fax _____

Gender
❒ Male
❒ Female

Application is for the school year:
20___ to 20___

For the grade indicated below:
❒ 3rd ❒ 6th
❒ 4th ❒ 7th
❒ 5th ❒ 8th

For the program indicated below:
❒ Cultural Study
❒ Academic Year

Height: _____

Weight: _____

Student's ethnic origin:
❒ Korean
❒ Chinese
❒ Japanese
❒ Vietnamese
❒ Hispanic
❒ African
❒ German
❒ French
❒Russian
❒Other_____

Parents are:
❒ Single
❒ Married
❒ Divorced

Family's religious affiliation: _____

How did you hear about Cornerstone Christian Academy? _____

CURRENT SCHOOL INFORMATION

_____
School Name Grade

_____
Address

_____
City Country Postal Code

_____
Principal's Name Email

_____
Special Awards or Recognition

STUDENT FAMILY INFORMATION

If parents are separated or divorced, with whom does the applicant reside?

❒ Father ❒ Mother ❒ Other: _____

Who has legal custody? _____

If parents are divorced, do you as the custodial parent want the other parent to receive copies of student reports and mailings? ❒ Yes ❒ No

Please list applicant's brothers and sisters

_____
Name Age

_____
Name Age

_____
Name Age

_____
Name Age

Do you have other family members studying abroad? Where?

_____
Name City, State

_____
Name City, State

STUDENT INFORMATION

How many years of English language have you had?

_____

What is your English ability?

❒ Low
❒ Average
❒ Intermediate
❒ Advanced

How long do you plan to study in the USA?

_____

Please check all sports, hobbies, and activities you enjoy:

❒ Football
❒ Soccer
❒ Volleyball
❒ Dance/Ballet/Hip-Hop
❒ Baseball
❒ Softball
❒ Track
❒ Ski/Snowboarding
❒ Tennis
❒ Gymnastics
❒ Horseback riding
❒ Karate/Tae kwon doe
❒ Water skiing
❒ Singing
❒ Musical Instrument _____
❒ Drama
❒ Photography
❒ Art
❒ Newspaper
❒ Movies
❒ Computer Games
❒ Television
❒ Chatting online
❒ Chess
❒ Cooking
❒ Traveling
❒ Crafts

Please check foods you enjoy:

❒ Chicken
❒ Beef/Hamburgers
❒ Pork/Ham/Bacon
❒ Pizza
❒ Spaghetti
❒ Chinese Food
❒ Mexican
❒ Pasta dishes
❒ Ramen Noodles
❒ Hot Dogs

If you can't be reached in case of an emergency, who should we contact?

_____

Name Relationship Phone

_____

Name Relationship Phone

PLEASE CIRCLE THE BEST ANSWER

What kind of Host family do you prefer?

A host family with small children	*YES*	*NO*	*NO PREFERENCE*
A host family with teenagers	*YES*	*NO*	*NO PREFERENCE*
A host family with no children	*YES*	*NO*	*NO PREFERENCE*
A host family with household pets	*YES*	*NO*	*NO PREFERENCE*
A host family without household pets	*YES*	*NO*	*NO PREFERENCE*
A host family that is active and busy	*YES*	*NO*	*NO PREFERENCE*
A host family that is quiet and calm	*YES*	*NO*	*NO PREFERENCE*
A host family that lives in the city	*YES*	*NO*	*NO PREFERENCE*
A host family that lives in the suburbs	*YES*	*NO*	*NO PREFERENCE*

Do you have a host family you are planning to live with? If yes, please complete this information:

_____

Name

_____

Address City State Zip

_____

Phone Fax E-mail

CONFIDENTIAL HEALTH INFORMATION (Please use additional paper for details, as needed)

1. Does your child have any chronic or recurring illness?

❒ Yes ❒ No If yes, please explain: _____

_____

_____

2. Does your child have any physical handicaps?

❒ Yes ❒ No If yes, please explain: _____

_____

_____

3. Has your child's school attendance ever been interrupted for a period of a month or more for medical reasons?

❒ Yes ❒ No If yes, please give approximate dates and details: _____

_____

_____

4. Are there any restrictions regarding your child's physical activities?

❒ Yes ❒ No If yes, please explain: _____

_____

_____

5. Has your child ever been hospitalized?

❒ Yes ❒ No If yes, please give approximate dates and details: _____

_____

_____

_____

6. Is your child currently under medical treatment?

❒ Yes ❒ No

If yes, please give reasons, medications prescribed and names and email addresses of doctors rendering treatment:

_____

_____

_____

_____

7. Has your child ever been treated by a psychiatrist/psychologist/counselor?

❒ Yes ❒ No

If yes, please list their name(s), email address (es), type of treatment received, approximate dates, and length of treatment:

_____

_____

_____

_____

_____

8. Has your child ever been prescribed or taken any drugs (such as Ritalin, Prozac, etc.) for behavioral, emotional, or scholastic reasons?

❒ Yes ❒ No If yes, please give details: _____

_____

_____

_____

9. Can your child participate in physical activities, including physical education?

❒ Yes ❒ No If no, please explain: _____

_____

_____

_____

10. Does your child have a history of any specific health problems or needs such as allergies, asthma, special diets, etc.?

❒ Yes ❒ No

If yes, please give details including any specific foods or medicines your child is allergic to. You may need to consult with your physician:

_____

_____

_____

_____

11. Has your child ever had any of the following? (Check yes or no. If yes, please give the year.)

Chronic cough	❒Yes	❒ No	Year: _____	Asthma	❒Yes	❒ No	Year: _____
Epilepsy or convulsions	❒Yes	❒ No	Year: _____	Hay fever	❒Yes	❒ No	Year: _____
Eye diseases	❒Yes	❒ No	Year: _____	Allergies	❒Yes	❒ No	Year: _____
Ear trouble	❒Yes	❒ No	Year: _____	Arthritis, Rheumatism	❒Yes	❒ No	Year: _____
Throat trouble	❒Yes	❒ No	Year: _____	Pneumonia	❒Yes	❒ No	Year: _____
Nose trouble	❒Yes	❒ No	Year: _____	Kidney or bladder disease	❒Yes	❒ No	Year: _____
Frequent colds	❒Yes	❒ No	Year: _____	Frequent headaches	❒Yes	❒ No	Year: _____
Sinus trouble	❒Yes	❒ No	Year: _____	Dizziness or fainting spells	❒Yes	❒ No	Year: _____
Heart disorders	❒Yes	❒ No	Year: _____	Fracture/broken bones	❒Yes	❒ No	Year: _____
Stomach trouble	❒Yes	❒ No	Year: _____	Diabetes	❒Yes	❒ No	Year: _____
Measles	❒Yes	❒ No	Year: _____	Typhoid	❒Yes	❒ No	Year: _____
Mumps	❒Yes	❒ No	Year: _____	Diphtheria	❒Yes	❒ No	Year: _____
Chicken pox	❒Yes	❒ No	Year: _____	Malaria	❒Yes	❒ No	Year: _____

German measles	❒Yes	❒ No	Year: _____	Infectious Mononucleosis	❒Yes	❒ No	Year: _____
Poliomyelitis	❒Yes	❒ No	Year: _____	Venereal disease	❒Yes	❒ No	Year: _____
Rheumatic fever	❒Yes	❒ No	Year: _____	Scarlet fever	❒Yes	❒ No	Year: _____
Whooping cough	❒Yes	❒ No	Year: _____	Meningitis	❒Yes	❒ No	Year: _____
Tuberculosis	❒Yes	❒ No	Year: _____	Hepatitis	❒Yes	❒ No	Year: _____

Please list anything in your medical history or present health status that has not been covered in this form, and which you think we should be aware of:

_____

_____

_____

_____

Child's Doctor's Name Phone Email

_____

INSURANCE INFORMATION

Is your child currently covered by any form of comprehensive health, medical, or accident insurance?

❒ Yes ❒ No If yes, please give details:

_____

Name of Insurance Company Policy Number

_____

Address City State Zip

_____

Phone Fax

_____

Extent of Coverage

_____

Policy Holder's Name Social Security Number

_____

Relationship to Child

Please photocopy the child's insurance card here:

INTERNATIONAL STUDENT ACADEMIC AND CULTURAL STUDY PROGRAMS

STUDENT QUESTIONNAIRE

STUDENTS: Please have student answer all the following questions in paragraph form in their own handwriting. Use additional sheets of paper if necessary.

_____

Student Name Applying Grade

How would your friends describe you? Please include a description of your personality, character, likes, dislikes, strengths, and weaknesses.

_____

_____

_____

_____

_____

_____

Why do you want to attend Cornerstone Christian Academy?

_____

_____

_____

_____

_____

_____

Have you lived away from home before? If so, what did you like best and least about the experience?

_____

_____

_____

_____

_____

Describe a class or teacher that you really enjoyed in school. What made that person or experience special?

_____

_____

_____

_____

_____

Describe the members of your family and your relationship with each one.

_____

_____

_____

_____

_____

_____

Describe what your parents wish for your future. What do you wish for your future?

_____

_____

_____

_____

_____

Is there anything else that you would like us to know about you?

_____

_____

_____

_____

Authorization for Medical Release of my Child

STUDENT INFORMATION

Last Name First Middle Nickname

Gender *(circle one)* Male Female

Date of Birth (Month/Day/Year)

PARENT INFORMATION

Fathers Name Mothers Name

Address

City Country Postal Code

Phone Parent E-mail Fax

EMERGENCY CONTACT – HOST FAMILY (to be completed in the United States)

Primary Emergency Contact Secondary Emergency Contact

Home Phone Work Phone Home Phone Work Phone

Address Address

City, State, Zip Code City, State, Zip Code

In the case of an emergency, we authorize Cornerstone Staff or their emissary to take my child for all medical and surgical treatment, X-Ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies in the event that neither the parent, guardian, nor Host Family member can be reached in the case of any emergency.

Parent's/Guardian's Signature Date

I give permission for my child to go to Cornerstone Christian Academy in the United States. I hereby release Cornerstone Christian Academy, its officers and employees, Host Families, agents and any other people officially connected with Cornerstone Christian Academy from liability in case of any accident related to Cornerstone Christian Academy or Host Family activities.

Parent's/Guardian's Signature Date

MEDICATION CURRENTLY TAKEN **FREQUENCY**

_____ _____

_____ _____

_____ _____

My student may take: *Tylenol (acetaminophen)* *YES NO*
Advil (Ibuprofen) *YES NO*

ALLERGIES

_____

_____

OTHER MEDICAL NEEDS OR MEDICAL CONCERNS

_____

_____

STUDENT'S PHYSICIAN

_____
Name Phone Number

STUDENT'S INSURANCE COMPANY

_____
Name Group/Member Number

CERTIFICATION OF INFORMATION

State: _____County: _____

Country: _____

On this _____ Day of_____20_____

(PARENT/STUDENT NAME)_____personally appeared before me,
_____Whose identity I verified on the basis of _____
_____Who is personally known to me.
_____Whose identity I verified on the oath/affirmation of _____
A credible witness, to be the signer of the foregoing document, and he/she acknowledges that he/she signed it.
This consent is authorization for the full duration of the student's participation in the enrolled program.

_____
Certifying Authority/Notary Public Commission Expire