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.)

International Visitor Emergency Card – Year 2011 - 2012

Heights Christian Schools – Chino Hills Campus • 2549 Madrugada Drive, Chino Hills, CA 91709 • 909-465-9905

Student's Name: Last	First	Middle	Sex: ☐ M ☐ F	DOB:	Grade:

Student lives in the USA with (check all that apply): ☐ Father ☐ Mother ☐ Guardian ☐ Host Family	American Name (if any):

Full Name of Father/Guardian:	Full Name of Mother:	Full Name of Host:

Host Address (street, city, zip)	Foreign Home Address City Providence/Territory Postal Code Country

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? ☐ Yes ☐ 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-Chino Hills 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:_____

CHINO HILLS CHRISTIAN SCHOOL
2549 Madrugada Drive, Chino Hills, CA 91709
(909) 465-9905 • e-mail: office@chinohillschristianschool.org
FAX (909) 902-0556 • www.chinohillschristianschool.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:** 6:00-8:00AM **LATE AFTERNOON**: 3:00-6:30PM 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