



APPLICATION FOR ADMISSION 2019-2020

Parents or legal guardians of the child must complete this form and submit the completed application to the attention of Keri St. John. Bynum School will contact parents to schedule an interview and to arrange a day for the child to visit classes.

Date Application Received _____
Date of Parent Meeting _____
Date of Free Day _____

Applicant Information

Name (Last, First, Middle) _____			Preferred Name _____
Home Address _____		City/State/Zip _____	Home Telephone _____
Date of Birth _____	Age _____	Current Grade/Placement _____	Preferred Date of Entry _____

Parent Information

Parent 1 _____		Parent 2 _____	
Home Address If Different from Child _____		Home Address If Different from Child _____	
City/State/Zip _____		City/State/Zip _____	
Telephone _____	Email _____	Telephone _____	Email _____
How did you learn about Bynum School?			
Browsing the internet _____	Recommendation _____		
Family of student _____	Who recommended Bynum School? _____		
Fundraiser _____	Staff _____		
Board Member _____	Advertisement _____		

Education/Services Information

Current Placement

Most Recent Evaluation

Diagnosis

Direct and Related Services

Physical Limitations

Pertinent Information

Reason(s) for Applying to Bynum School

Attach documentation of your child's diagnosis as it was given by a physician, psychiatrist, psychologist, or other qualified professional. Assessment/evaluation reports are required before the application can be processed. Also include a copy of the most recent IEP, if applicable. Mail or deliver this completed form and documentation to:

Keri St. John, M.Ed.

Head of School for Student Programs and Services

Bynum School

5100 Avalon Drive

Midland, Texas 79707

(432) 520-0075 phone (432) 520-0076 fax

With God's grace, Bynum School, remaining committed to the ideals of dignity and respect, will provide personalized educational programs to meet the academic, behavioral, and vocational needs of individuals of all ages with special needs.

STUDENT MEDICAL HISTORY

Student: _____ **DOB:** _____

MEDICAL DIAGNOSIS _____

ALLERGIES _____

BLADDER/BOWEL

Frequent UTI's ☐ yes ☐ no

Constipation ☐ yes ☐ no

BLOOD DISORDERS

Explain: _____

EARS

Hearing problems ☐ yes ☐ no

Hearing aid(s) ☐ yes ☐ no

Frequent infections ☐ yes ☐ no

Speech Problems ☐ yes ☐ no

Surgery ☐ yes ☐ no

ENDOCRINE

Diabetes – Type _____

Date Diagnosed _____

Treatment Regimen _____

Diabetes Physician _____

Phone #: _____

EYES

Vision problems ☐ yes ☐ no

Wears contacts ☐ yes ☐ no

Wears glasses ☐ yes ☐ no

GASTROINTESTINAL

Upset stomach ☐ yes ☐ no

Diarrhea ☐ yes ☐ no

Emotional upsets ☐ yes ☐ no

ORTHOPEDIC

Orthotics/Braces ☐ yes ☐ no

Ambulatory Equipment ☐ yes ☐ no

History of fractures ☐ yes ☐ no

Loose joints ☐ yes ☐ no

HEART

Congenital Heart Disease ☐ yes ☐ no

Cardiac Surgery – Type: _____

ADD/ADHD

Medication: _____

Physician & Phone# _____

NEUROLOGICAL

Seizure Action Plan required

Febrile Seizures ☐ yes ☐ no

Seizure disorder ☐ yes ☐ no

Briefly describe seizure _____

Seizure Emergency medication: _____

Meningitis ☐ yes ☐ no

Cerebral palsy ☐ yes ☐ no

Migraines ☐ yes ☐ no

RESPIRATORY

Asthma Action Plan required

Inhaler/nebulizer treatment: _____

Food & medication allergies _____

EPI-PEN

Food Allergy Action Plan required

Physician _____

SKIN

Rashes ☐ yes ☐ no

Hives ☐ yes ☐ no

Insect Bites Allergy ☐ yes ☐ no

SURGERIES

Type _____ Year _____

Type _____ Year _____

Will your child require any medical treatments/medications while at school? (Ex: Nebulizer, tube feeding)

List all current medications: _____

Any special instructions: _____