VINEYARD CHRISTIAN SECONDARY SCHOOL

Family • God • Education

Admission Information

15310 Huebner Rd. • San Antonio, TX 78248 210-479-5853 • www.vcsssa.org • info@vcsssa.com

2024– 2025 Academic Year

Director's Name: _____

Student's Information

Last Name	First Name	Middle Initial	Grade/Group	Date of Admission Ex. 04/23/2001
				/ /

Ethnicity ☐Caucasian ☐Hispanic ☐African-American ☐Asian/Pacific ☐American Indian ☐Other _____

Date of Birth Ex. 04/23/2001	Social Security Number	Gender ☐Male ☐Female	Home Telephone No.
/ /			

Street Address	City	State	Zip Code

Student Lives With? ☐Both Parents ☐Mom ☐Dad ☐Guardian	Custody Documents on File? ☐Yes ☐No	Date of Withdrawal Ex. 04/23/2001
		/ /

Parent/Guardian 1 Information

Last Name	First Name	Middle Initial

Street Address (*if different from child's address*)	City	State	Zip Code

Social Security Number	Occupation	Employer

List telephone numbers below where parent/guardian may be reached while student will be in VCSS care:

Home Telephone No.	Work Telephone No.	Cell Phone No.	Email

Ethnicity ☐Caucasian ☐Hispanic ☐African-American ☐Asian/Pacific ☐American Indian ☐Other _____

Parent/Guardian 2 Information

Last Name	First Name	Middle Initial

Street Address (*if different from child's address*)	City	State	Zip Code

Social Security Number	Occupation	Employer

List telephone numbers below where parent/guardian may be reached while student will be in VCSS care:

Home Telephone No.	Work Telephone No.	Cell Phone No.	Email

Ethnicity ☐Caucasian ☐Hispanic ☐African-American ☐Asian/Pacific ☐American Indian ☐Other _____

Other adults living at home with the family: _____/relationship _____

_____/relationship _____

Sibling Information

Name of sibling attending VCS/VCSS	Grade	Name of sibling attending VCS/VCSS	Grade

Student Pickup Authorization

*I hereby authorize VCSS to allow my child to leave VCSS **ONLY** with the following persons. Please list name & telephone number of each. Student will only be released to a parent or a person designated by the parent/guardian after verification of ID.*

Full Name	Relationship	Telephone No.
Full Name	Relationship	Telephone No.
Full Name	Relationship	Telephone No.

Agreements

Transportation I hereby ☐give ☐do no give – consent for my child to be transported and supervised by the operation's employees:

☐for emergency care ☐on field trips ☐to and from home ☐to and from school

Extended Care Service:

☐Mondays

☐Tuesdays

☐Wednesdays

☐Thursdays

☐Fridays

☐Before school (7:00 am – 8:00 am)

☐After school (3:45 pm – 6:00 pm)

Web and Media:

Throughout the school year, students may be highlighted in efforts to promote VCSS activities and achievements. No full names of students are ever to be used on the Internet in conjunction with pictures and videos.

We will not re-use any photographs or recordings a year after your child leaves this school. Historic photographs will remain on our school website and social media feeds.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing or by email.

☐**I give** my consent for my child's photography and video to be used by VCSS for advertising on any electronic media outlet, print media outlet, and internet.

☐**I do not give** my consent for my child's photography and video to be used by VCSS for advertising on any electronic media outlet, print media outlet, and internet.

By signature below, I release VCSS, employees or other representatives from any liabilities, known or unknown, arising out of the use of this material.

Signature – Parent or Legal Guardian

Date

Receipt of Written Operational Policies

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

- ☐ Discipline and guidance
- ☐ Suspension and expulsion
- ☐ Emergency plans
- ☐ Procedures for conducting health checks
- ☐ Procedures for parents to discuss concerns with the director
- ☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
- ☐ Procedures for parents to participate in operation activities
- ☐ Procedures for release of children
- ☐ Illness and exclusion criteria
- ☐ Procedures for dispensing medications
- ☐ Immunization requirements for children
- ☐ Meals and food service practices
- ☐ Procedures for supporting inclusive services

Student's Special Care Needs

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations (past 12 months)
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment (include instructions below)
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

_____

_____

_____

Does the student have diagnosed food allergies? ☐ Yes ☐ No Food Allergy Emergency Plan Submitted Date: _____

_____ _____

Signature – Parent or Legal Guardian Date

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Student's Name

Student's Last Name	Student's First Name	Student's Middle Initial
Student's Date of Birth Ex. 04/23/2001 / /		

Emergency Contact

Give the name, address and phone number of person to call in case of an emergency if parents/ guardian cannot be reached:

Last Name	First Name	Middle Initial	
Street Address	City	State	Zip Code
Home Telephone No.	Work Telephone No.	Cell Phone No.	
Relationship			

Authorization for Emergency Medical Attention

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to make the necessary emergency medical care arrangements and to have the student transported for emergency medical treatment.

Signature – Parent or Legal Guardian

Doctor's Information

Name of health care professional		Telephone No.	
Street Address	City	State	Zip Code

Signature – Parent or Legal Guardian

Date

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Student's Name

Student's Last Name	Student's First Name	Student's Middle Initial

Health Notes

List any medical condition that your child may have, such as allergies, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which VCSS employees should be aware of:

_____

Immunization Record

The Texas Department of Health has ruled that students must be current with immunizations in order to attend school unless an exemption has been filed with the school in accordance with Texas Education Code. All immunizations must be completed by the first date of attendance. If the student has not received the required doses of vaccination, the student is not in compliance and the school shall exclude the student from school attendance until the required dose is administered.

☐ I include with this application a copy of my child's most current immunization record.

Varicella (chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement:

My child had varicella disease (chickenpox) on or about (date) ____/____/____ *and does not need varicella vaccine.*

_____ _____
Signature – Parent or Legal Guardian Date

For additional information regarding immunizations visit www.dshs.state.tx.us/immunize/public.shtm

Vision and Hearing Score

VISION	R 20/____	L 20/____	☐ PASS ☐ FAIL

_____ _____
Signature Date

HEARING	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
R				
L				

_____ _____
Signature Date

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

School Age Children

☐ My child attends the following school:	School Name		
Street Address	City	State	Zip Code
Telephone No.	*Check all that apply:*		

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

My child has permission to:

☐ ride a bus, and/or ☐ walk to and from school,

☐ be released to the care of his/her sibling(s) under 18 years old.

Name of sibling	Name of sibling

Requirements for Exclusion from Compliance

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Signature – Parent or Legal Guardian

Date

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm

TB Test (If required)

☐ Positive ☐ Negative Date _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a school is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

_____ _____

Signature – Parent or Legal Guardian Date

_____ _____

Center Designee Date

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

_____ _____

Signature Date

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Student's Name: _____ Teacher's Name: _____ Grade: _____

I hereby certify that I have received the 20__ – 20__ Vineyard Christian School Secondary School handbook, and have read and agree to the guidelines contained herein.

I will direct any and all questions to the Director and/or Owner.

I understand that these guidelines may be changed at any time and will be applicable to all clients including those enrolled prior to change.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date

After signing, promptly return this page to the Office, it will be kept in the student's file. Keep the copy of this handbook for your reference throughout the year.

"Hear my children the instruction of a Father, and give attention to know understanding…"
Proverbs 4:1

Breakfast and Lunch Program 2024–2025

VCSS offers breakfasts and lunches for the students available for purchase. Please, complete the form below about the breakfast and lunch program.

I want my child, _____, to participate in the following breakfast and lunch program:

_____ $2.50 per day. Only breakfast.
_____ $68 montly. No breakfast, only lunch.
_____ $10 monthly. No breakfast, no lunch, but will have milk and fruits from school.
_____ No breakfast, no lunch, no milk or fruits from school.

Your monthly statement will reflect the amount due for the upcoming month.

_____ _____
Signature Date
Parent or Legal Guardian