

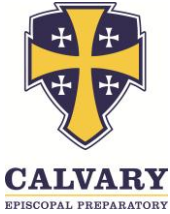


CALVARY
EPISCOPAL PREPARATORY

REQUIRED DOCUMENTS TO ISSUE AN I-20

Please submit the following documents/information

- Proof of Financial Support (Page 2)
- Host Family & Guardianship Information (Page 3)
- Health Insurance Information (Page 4)
- Student Immunizations (Page 4)
- Medical Information Form (page 5-6)
- If transferring an I-20, please supply the I-94



PROOF OF FINANCIAL SUPPORT

Parents must provide proof of financial support showing who is financially responsible for the student while the student is studying in the United States.

Letter must be on bank letter head and include:

1. Letter **MUST** be from a reputable bank
2. Letter **MUST** be signed by a bank officer
3. Letter **MUST** state that parents, guardian or student has an account of at least \$35,000.00.
4. Letter **MUST** list date account was opened
5. Letter **MUST** present balance
6. Letter **MUST** have date stamp



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HOST FAMILY & GUARDIANSHIP INFORMATION

I-20 Students **MUST** be living with their legal guardian while living in the United States.

Student's full legal name _____

Student's nickname _____

Home Address _____

City/County/State _____ Zip _____

Home Telephone _____

Student Name _____ Grade _____

Host Father _____ Employer _____

Business Phone _____

Cell Phone _____

Host Mother _____ Employer _____

Business Phone _____

Cell Phone _____

Host Parent Email Address _____

Person Responsible for paying tuition _____



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HEALTH INSURANCE & IMMUNIZATION

HEALTH INSURANCE

I-20 students **MUST** purchase student insurance while in the United States. Please be aware that student insurance must be active for the entire time the student is in the USA. It must be paid in full, in advance, of each school year in order for the student to attend school.

You are welcome to explore different insurance companies on your own or use one of the companies our students have used in the past:

- a. Academic Health Plans - <http://www.ahpcare.com/>
- b. International Student Insurance - <http://www.internationalstudentinsurance.com/major-medical-insurance/>
- c. ISO Student Health Insurance – www.isoa.org

Once you've chosen your insurance, please submit a copy of your insurance card to Calvary.

IMMUNIZATION RECORD

I-20 students **MUST** provide a completed immunization record, prior to the first day of school. Immunization must be translated into English. It needs to also include a TB test, done prior to entering the United States. See attachment "Texas Minimum State Vaccination Requirements for Students K-12" for details on immunizations



STUDENT INFORMATION & EMERGENCY FORM

School Year _____

Student's Name: _____ Nickname: _____
(First) (Middle) (Last)

Student's Address: _____ Birthdate: _____

Parents' Marital Status: _____ Student primarily lives with: _____

Mother's Name: _____ Home Phone: _____ Cell Phone: _____

Mother's Employer: _____ Work Phone: _____

Work Address: _____ Email Address: _____

Father's Name: _____ Home Phone: _____ Cell Phone: _____

Father's Employer: _____ Work Phone: _____

Work Address: _____ Email Address: _____

Emergency Contact: _____
(other than parent) (Name) (Relationship) (Phone)

(Name) (Relationship) (Phone)

Physician's Name: _____ Phone: _____

Address: _____ Fax #: _____

Dentist's Name: _____ Phone: _____

Address: _____ Fax #: _____

Preferred Hospital: _____ Phone: _____

Address: _____

This child will be picked up from (PLEASE MARK ONLY ONE): carpool walk-up extended day

This child may be released **ONLY** to the following persons age 18 or older.

(Include all parents/guardians or designees.)

Name:	Relationship:	Phone:



STUDENT HEALTH HISTORY

Student Name _____

CONFIDENTIAL MEDICAL INFORMATION—Must be completed each year.

Place a check mark in the box next to any conditions that your child has. Please provide thorough information.

- NO MEDICAL HISTORY OR CONDITIONS**
- Allergies to food** _____ Reaction _____ Treatment _____
- Allergies to medication** _____ Reaction _____ Treatment _____
- Allergies (seasonal)** _____ Reaction _____ Treatment _____
- Allergies (other)** _____ Reaction _____ Treatment _____

***Are any of the above allergies life threatening? Yes / No (circle one) If yes, please provide an Allergy Action Plan.

ADD or ADHD (please circle) Medication: _____ Once or Twice daily (circle one)

Asthma / Respiratory Problems (circle one) Medication: _____ Inhaler at school? Yes / No

***If your child has asthma, please provide an Asthma Action Plan.

Auto-immune Disorder (please explain) _____ Medication _____

Blood Disorder (please explain) _____ Medication _____

Diabetes Type 1 or 2 (circle one) Medication _____ Blood sugar checks at school? Yes / No

***Please provide a Diabetes Medical Management Plan for School

Eating Disorder (please explain) _____

Ear Infections (frequent) Left / Right / Bilateral How often? _____

Heart Condition _____ Medication _____ Restrictions _____

Migraines / Frequent Headaches How often? _____ Medication _____

Musculoskeletal Condition (please explain) _____ Medication _____

Neurodevelopmental (please explain) _____

Nosebleeds (frequent) How often? _____

Physical Impairments (please explain) _____ Assistance needed _____

Seizures Type & description _____ Medication _____

***Please provide a Seizure Action Plan.

Stomach Conditions (please explain) _____ Medication _____

Urinary / Kidney / Bowel Conditions (please explain) _____ Medication _____

Other (please explain) _____ Medication _____