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

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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

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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:

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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_____