

Sinai Christian Academy

2301 Grier Ave, Linden, NJ 07036

Phone: (908) 486-2006 Fax: (908) 925-9258

Sinai Christian Academy School Admissions Procedure (1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th Grades)

1. Do the Following:
 - ☐ Complete Application
 - ☐ Sign Release of Records for previous school
 - ☐ Give Teacher Recommendation Form to child's teacher
 - ☐ Give Church Recommendation Form to a church leader
(who knows your child well)
2. Gather the following documents:
 - ☐ Birth Certificate
 - ☐ Social Security Card
 - ☐ Immunization Records
 - ☐ Copies of previous Report Card
 - ☐ Standardized Test results
 - ☐ IEP/ISP (if your child is classified)
3. ☐ Bring the completed Application and Documents with the Non-refundable Registration Fee to Sinai Christian Academy.
4. ☐ Once all the documentation is received, the office will schedule an interview appointment with parent(s) and child.
5. ☐ Pay Insurance and Curriculum Fee within 3 days of acceptance, if before June (if accepted after June, fees will be due immediately).
6. ☐ Schedule Child for a Physical with your doctor and bring report and health history records to school.
7. ☐ Pay tuition by due date in the months of Aug through May.
8. ☐ The yearly fundraiser is \$900. Please advise if you would like to include it in the tuition or you will be participating in raising the funds.

***If ALL items on this form are not submitted your child will be denied admittance**

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New Student Application 2025-2026

Child's Name:	Birthdate:	Gender:
Father's Name	Mother's Name	
Address	Address	
City, State, Zip	City, State, Zip	
Home Phone Number	Home Phone Number	
Cell Phone Number	Cell Phone Number	
Work Phone Number	Work Phone Number	
E-Mail Address	E-Mail Address	
Father's Employer	Mother's Employer	
Address	Address	
City, State, Zip	City, State, Zip	
Position	Position	
<u>For Office Use Only:</u> __ Application Fee Date & #: _____ __ Completed Application __ Curriculum Fee Date & #: _____ __ Copy of Birth Certificate __ Copy of Immunizations Date: _____ __ Physical __ School Records Received __ IEP/ISP Received __ Pastoral Recommendation __ Educational Recommendation __ Interview Date: _____	<u>Are Natural Parents?</u> __ Married __ Not Married __ Separated __ Divorced __ Deceased (Mother or Father) Who has legal custody of this child? Is this a legal guardian? _____ Copies of Documentation: _____ Court Order Attached? _____ _____	

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Page 2

Child's Name:	Birthdate:	Gender:
Child's Social Security Number	Current School	
Place of Birth	Address	
City, State, Zip	City, State, Zip	
Is student US citizen?	School Phone Number	
If not, what is his/her status?	School Previously Attended and Years/Grades attended	
Student's e-mail address	Address, City, State, Zip	
Student's Cell Phone Number	School Previously Attended and Years/Grades attended	
Primary Language Spoken at home	Address, City, State, Zip	
Other Language(s) Spoken	School Previously Attended and Years/Grades attended	
<u>Ethnic Background:</u> Check all that apply		
<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islands <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		
1) Has applicant ever repeated a grade? _____ If yes, which grade(s)? _____ 2) Has applicant ever been suspended or expelled? _____ 3) If yes, for what reason? _____ 4) Has applicant ever received in-school suspension? _____ 5) Has student been evaluated by a Child Study Team and/or classified? _____ 6) Has applicant been convicted of a crime? _____		

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STUDENT PHYSICAL QUESTIONNAIRE 2025/2026

To be completed by a physician

Please complete all the information in its entirety and attach a copy of a child's current immunization records. It is also necessary for a child to have a complete physical.

Student's Name:	Birthdate:	Grade:	
Does child have allergies? What?			
What type of reaction or symptoms?			
Child's treatment for allergic reaction:			
Does child have asthma?			
If yes, what are his/her triggers?			
Child's asthma treatment:			
Does child use inhaler or nebulizer?			
List any other medical conditions:			
List medications:			
Does child have speech, hearing, or visual difficulties?			
Diagnosed with ADD, ADHD, or Sensory sensitivity?			
Is child receiving special services?			
If yes, please explain:			
<u>Please circle if child has problems with any of the following:</u>			
Constipation	Convulsions	Diarrhea	Fainting Spells
Frequent Colds	Frequent Ear Infections	Frequent Sore Throats	Lice
Ringworm	Skin Rash	Stomach Upsets	Soiling
Urinary Problems	Worms	Lead Poisoning	
<u>Please circle if child has ever had any of the following:</u>			
Asthma	Bronchitis	Chicken Pox	Diabetes
Heart Disease	Hepatitis	Impetigo	Measles
Mumps	German Measles	Polio	Scarlet Fever
Tuberculosis	Whooping Cough	Kidney Disease	Sickle Cell
<u>Please provide any other medical information you deem necessary for Sinai Christian Academy to be aware of:</u>			

Physician's Signature

UNIVERSAL CHILD HEALTH RECORD

*Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health*

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last)		(First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number		Work Telephone/Cell Phone Number	
Parent/Guardian Name		Home Telephone Number		Work Telephone/Cell Phone Number	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormalities Noted:					Weight (must be taken within 30 days for WIC)
					Height (must be taken within 30 days for WIC)
					Head Circumference (if <2 Years)
					Blood Pressure (if >3 Years)
IMMUNIZATIONS		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the signs/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.</i>					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

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Early Childhood Department

Page 3

Child's Name: _____

About Your Child

1. Has your child ever been in a daycare or preschool setting?
2. If yes, what type?
3. Was it a positive experience for him/her?
4. Why are you enrolling your child at Sinai Christian Academy?
5. Has your child been exposed to any traumatic events such as a death in the family, divorce, birth of a sibling, etc?
6. What is your child's temperament? Is he/she compliant, easy going, demanding, aggressive, pleasant, etc?
7. What is your method of discipline?
8. Does your child have any dietary restrictions? Are there food allergies?
9. What are your child's favorite foods?
10. Are there any foods that your child particularly dislikes?
11. Is your child reliable in conveying his/her bathroom needs?
12. What words does he/she use for bowel movements?
13. What words does he/she use for urination?
14. At what time does your child wake up in the morning?
15. At what time does your child go to sleep at night?
16. Does he/she sleep through the night?
17. Does he sleep in a bed, crib, or other?
18. Does your child have siblings? If yes, please complete following:
Name: _____ Age: _____ Gender: _____
Name: _____ Age: _____ Gender: _____
19. Has your child had experience playing with other children?
20. What language(s) are spoken at home?
21. Does your child have any security objects, such as a blanket or toy?
22. What are your child's favorite activities, books, toys, etc?
23. Do you have any specific concerns?

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Church Reference Form

To be completed by the prospective student's Pastor, Church Elder, Youth Leader, Sunday School teacher, or Ministry Leader who can best answer questions concerning the student. Please mail completed form directly to Sinai Christian Academy. Thank you.

Student's Name: _____ Entering Grade: _____

Parent/Guardian: _____ Date Submitted: _____

1) How long has this family attended your church? _____

2) How frequently does he/she attend services? _____ Weekly _____ Monthly _____ Rarely

3) In your opinion, does the student have a personal devotion to Jesus? _____

4) If yes on what evidence are you basing this? _____

5) Does the student have a positive attitude toward authority and instruction? _____

6) On what evidence are you basing this? _____

7) Does the student have any physical, emotional, or personality traits which could potentially impact his/her relationship with others? _____

8) If yes, please explain (continue on back): _____

Signature: _____ Date: _____

Your Printed Name: _____ Position/Title: _____

Church Name: _____

Address: _____ Phone #: _____

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Application Certification

Students Name: _____
Birthdate: _____ Grade: _____

I/We attest that all of the information presented on this form is true, accurate, and complete. I/We authorize the SCA School Board to release this form and all attachments to pertinent parties, and to confirm that the information included herein is indeed accurate.

I/We understand that this application will not be processed without the requested documentation attached. In addition, I/We understand that any false information provided will result in the student not being accepted and/or discharged from Sinai Christian Academy.

Parent/Guardian: _____ Date: _____
Parent/Guardian: _____ Date: _____

Certificamos / confirmamos que toda la información presentada en este formulario es verdadera, precisa y completa. Autorizo / autorizamos a la Junta Escolar de SCA a entregar este formulario y todos los anexos partes pertinentes, y a confirmar que la información incluida en este documento es realmente precisa. Entiendo/ entendemos que esta solicitud no se procesará sin la documentación solicitada adjunta. Entiendo que cualquier información falsa resultará en que el estudiante no sea aceptado y/o dado de baja de Sinai Christian Academy.

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STUDENT PICK-UP FORM

Student Name(s): _____ Grade(s): _____

Student Name(s): _____ Grade(s): _____

Student Name(s): _____ Grade(s): _____

Student Name(s): _____ Grade(s): _____

Mother's Name: _____

Father's Name: _____

Home Phone #: _____

Home Phone #: _____

Cell Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Work Phone #: _____

Sinai Christian Academy ("SCA") is hereby authorized to release my children to the following individuals:

<u>Name</u>	<u>Address & Phone Number</u>	<u>Copy of License/I.D.</u>
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1. _____

2. _____

3. _____

I understand that each of these individuals must provide current I.D. to the office staff (i.e., driver's license) and a copy will be made to keep with the school's records. **Furthermore**, I understand that it is my responsibility to contact the school office and notify SCA that there is a change in the regular pick-up procedure. I also understand that my child(ren) will not be released to any individual not on this list. I must contact SCA to complete a new form should the information on this form change, or I wish to add or remove anyone from this authorization.

The following individuals have been prohibited from picking up my child(ren) by Court Order/Restraining Order (copy attached).

<u>Name</u>	<u>Address & Phone Number</u>	<u>Attach Photo (if available)</u>
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1. _____

2. _____

Signature

Date

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STUDENT REFERRAL PROGRAM

Dear Parents:

Great News! We have expanded our student referral program. Refer your family and friends to Sinai Christian Academy and receive a discount on your 2025/2026 tuition.

The referral program will work as follows:

Refer	Receive
Refer 1 Family	\$300 off 2025/2026 tuition
Refer 2 Families	\$600 off 2025/2026 tuition
Refer 3 Families	\$1000 off 2025/2026 tuition
Refer 4 Families	\$1500 off 2025/2026 tuition

Reduction in tuition will be reduced at the end of the 2025/2026 school year provided the referral family and the referred family remains registered for the 2020/2021 school year and the referred family's tuition is paid in full.

Reduction in tuition is not to exceed total of referring family's yearly tuition.

If you have any questions, please call the main office at 908-486-2006.



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OFF-PREMISES CONSENT FORM 2025-2026

I hereby give permission for the staff of Sinai Christian Academy ("SCA") teachers and staff to take my child(ren) off school premises to participate in local school events, which may include, a local park, the fire department, or other community locations, as well as participating in gym activities which are off premises at a local park. I understand that this permission slip allows my child(ren) to ride SCA's school bus to various locations.

Name(s) of Child(ren)

Parent/Guardian Signature

Date

Emergency Contact Number _____