



**San Fernando Valley Professional School**  
**School4stars.com**  
**6215 Laurel Canyon Blvd., North Hollywood, CA 91606**  
**Telephone (818) 985-9485 Fax (818) 985-5693**

**Application For Admission**

Student Name \_\_\_\_\_  
Last First Middle

{ } M { } F Grade \_\_\_\_\_ Birth Date \_\_\_\_\_ Date Entered. \_\_\_\_\_  
Month/Day/Year

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Apt.

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Secondary Apt.

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Last School Attended \_\_\_\_\_ Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address if different \_\_\_\_\_

Employer's Name \_\_\_\_\_ Daytime Phone# \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address if different \_\_\_\_\_

Employer's Name \_\_\_\_\_ Daytime Phone# \_\_\_\_\_

Parent/Guardian's e-mail address \_\_\_\_\_

Student's Cell Phone# \_\_\_\_\_ Ethnicity (Optional) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_ Day Phone \_\_\_\_\_ Relationship to student \_\_\_\_\_

Name \_\_\_\_\_ Day Phone \_\_\_\_\_ Relationship to student \_\_\_\_\_

Date Received \_\_\_\_\_ (office use only)

San Fernando Valley Professional School offers open enrollment and shall not discriminate against any applicant on the basis of race, sex, color, ethnic origin.

## HEALTH CARE PROVIDER INFORMATION

Name of Physician \_\_\_\_\_ Phone # \_\_\_\_\_ Health Plan \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Policy # \_\_\_\_\_

## HEALTH RECORD

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> TB	<input type="checkbox"/> Speech Difficulty
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Tires easily	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Hard of Hearing
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Frequent Urination

Date of Last physical exam \_\_\_\_\_ Wears glasses/contacts Yes \_\_\_ No \_\_\_

## ALLERGIES

<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Eczema
<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Food Allergies

Please specify: \_\_\_\_\_

Please indicate if your child is on any special medication Yes / No. If yes, please specify the name and the purpose below.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Take Rx during school hours Yes \_\_\_ No \_\_\_

## IMMUNIZATIONS

Dates for each vaccine:

_____ Smallpox	_____ DPT	_____ Measles
_____ German Measles	_____ Polio	_____ TB