St. Ignatius Loyola Early Learning Center

Faith in Every Child

2700 St. Albans Drive ◆ West Lawn, PA. 19609

◇ Birth Certificate	◇ Baptismal Certificate
◇ Immunizations	◇ FACTS Registration
◇ Medical Forms	◇ Accept
◇ Dental Forms	◇ Option C
◇ Rel. Ed Forms	◇ Parish Verified

FOR OFFICE USE

FACTS Option_____

Reg. Fee $ _____Activity Fee $ _____

Check No. _____ Date _____

3 Day AM____ Full____ (M-W-F)

4 Day AM____ Full____ (M-T-W-TH)

5 Day AM____ Full____ (MON-FRI) Referred by_____

Registration

Pre Kindergarten

Student Name _____ (First) _____ (Middle) _____ (Last) _____ (Name to be used in school)

Home Address _____ (Street) _____ (City) _____ (State) _____ (Zip) _____ (Home Phone)

Guardianship _____ _____ (Name of step parent (if applicable)) _____ (Phone)

Is your child adopted? ☐ Yes (please provide adoption certificate) ☐ No

Child's Age _____ Date of birth _____ Place of birth _____

Person Financially responsible for tuition;_____ (Please note: Tuition rates are based on active membership of child and parent/guardian either at St. Ignatius Loyola or St. Francis de Sales Parish)

Father's Name _____ (Last) _____ (First) _____ (Address if different from student's) _____ (Phone if different from student's)

☐ Check if deceased Father's place of birth_____

Father's Daytime Phone _____ Employer _____ _____ (City) _____ (State)

Father's Occupation _____ Father's Education _____

Father's Cell Phone/Pager _____ Father's E-mail Address _____

Marital Status _____ Religion _____ Parish _____

Mother's Name _____ (Last) _____ (First) _____ (Address if different from student's) _____ (Phone if different from student's)

☐ Check if deceased Mother's place of birth_____

Mother's Daytime Phone _____ Employer _____ _____ (City) _____ (State)

Mother's Occupation _____ Mother's Education _____

Mother's Cell Phone/Pager _____ Mother's E-mail Address _____

Marital Status _____ Religion _____ Parish _____

Emergency Contact (other than parents) and Medical Information

Name _____ _____ _____ _____ ☐cell ☐home ☐work
Last First relationship Phone

Name _____ _____ _____ _____ ☐cell ☐home ☐work
Last First relationship Phone

Student Physician _____ Phone _____

Student Dentist _____ Phone _____

Allergies _____ Treatment _____
food, drug, bee sting, other

I, the parent/guardian of , the parent/guardian of_____ authorize St. Ignatius Loyola Regional School , in the Wilson School District, personnel to provide first aid services to my child as stated in the standing orders prescribed by the Wilson School District physician. In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to make whatever arrangements appear necessary for the immediate care of my child.

Hospital preferred _____ (In an emergency requiring so, the nearest hospital will be used.)

I give my permission for the school nurse or her designee to administer the following medications to my child according to the school's standing medication orders:

YES	NO

Acetominophen (fever, headache, pain) (Provided by Parent)
Benadryl (allergic reactions) - Please note, the nurses avoid using Benadryl for mild seasonal allergies since it may make students sleepy, however it is possible it may be needed for more serious allergic reactions such as hives, insect sting and food reactions, etc.
Tums or Mylanta (upset stomach)
Ibuprofen (cramps, muscular/skeletal pain, severe headaches) (Provided by Parent) 7th & 8th Grades only

_____

_____

Parent or legal guardian signature **Date**

Note: The following first aid supplies (or their generic substitutes) are also used to treat students in the health room: EpiPen Kit- for severe allergic reactions, Albuterol- for severe breathing difficulty (Parents should provide students' own EpiPen or asthma meds when known problem), Bacitracin ointment, sterile eyewash (eye irritation or foreign body in eye), PhisoDerm cleanser, alcohol, calamine lotion, sterile saline solution (contact lenses), vinyl and latex gloves. If your student has an allergy to any of these products, please list the allergy on the "Food and drug allergy" line below.

LIST ALL CURRENT MEDICATIONS:

Medication/Dosage/Time Given:	Taken For:

STUDENT'S MEDICAL HISTORY: Please check yes or no for each

	Yes	No	Explain further where needed
ADD/ADHD			
Asthma			
Diabetes			
Bee Sting Allergy			
Glasses/Contacts			For distance, near, or constant wear:
Hearing Difficulties			
Seizure Disorders			
History of major illnesses or surgeries			List:
Condition limiting physical education			Describe:
Other chronic or recurrent condition			List:

If you have answered **yes** to any of the above health conditions, please write the plan of action you want the school nurse to take when the health condition arises. The school nurse may need to contact you to have a medical plan of action completed by your child's physician.

Child's Gender ☐ Female ☐ Male
Check one

Entering Grade ____ Number of Brothers ____ Number of Sisters ____

Is another language spoken at home? ☐ Yes,_____ ☐ No

Does your child have speech difficulty? _____ Does your child have hearing difficulty? _____

Does your child have any particular fears that we should know about? _____

Does your child exhibit any particular habits (thumb sucking, nail biting, etc)? _____

Has your child received any special services (counseling, etc)? ☐ Yes, because _____ ☐ No

What are your child's strengths and interests? _____

Other comments

_____

_____

_____

The following individuals are authorized to pick up my child from Saint Ignatius Loyola Preschool.

1._____ 3._____

2._____ 4._____

5._____ 6._____

St. Ignatius Loyola Preschool
Faith in Every Child
2700 St. Albans Drive ◆ West Lawn, PA. 19609

Diocese of Allentown
HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for identification.

School District: _____

Name of Child: _____ **Date:** _____

Address: _____ **Grade:** _____

School: _____ **Birthplace:** _____

1. What is/was the student's first language? _____
2. Does the student speak a language(s) other than English? ☐ Yes ☐ No

   If yes, specify the language(s): _____
3. What language(s) are spoken in your home? _____
4. Has the student attended any United States school in any 3 years during his/her lifetime? ☐ Yes ☐ No

   If yes, complete the following:

Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person completing this form (if other than parent/guardian): _____

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Tuition Payment Preference Form

Parent/Guardian Name _____

Student Name(s) and Grade(s) _____

Pre-Kindergarten-Grade 8

☐ **OPTION 1** – Single payment due June 1. **Amount due $** _____
2% discount is applicable to tuition of first child, in K-8 only, if received on or before June 1.

☐ **OPTION 2** – Two payments due June 1 and December 1. **Amount due $** _____

☐ **OPTION 3** – **FACTS** monthly payment plan. Payments are budgeted over a 12 month period beginning in June. Payment will automatically be withdrawn from your account on the 5th or 20th of the month.

Amount due each payment $ _____

PLEASE NOTE: If you select Option 3 you will be charged an administrative fee of $35.00 from **FACTS** Management Company.

I agree to make tuition payments according to one of the options above.

_____ _____
Parent/Guardian Signature Date

ST. IGNATIUS OF LOYOLA
OFFICE OF RELIGIOUS EDUCATION

R: 1/95

Parish Sacramental Information - Please complete for <u>each</u> student being registered in St. Ignatius School.

Student Information:

Student Name: _____
First Middle Last

Date Registered in School: _____ Sex: _____ Grade: _____

Marital Status of Parents: _____ Child resides with: _____

Mailing Information: Please complete for Parent/Guardian

Name: _____

Address: _____

City: _____

Phone: Home: _____ Father Work: _____ Mother Work: _____

Parish Registration: ☐ St. Ignatius ☐ Other (Explain) _____

In what Religion/Faith is this child being raised: _____

Parent Information:

<u>Birth</u> Father: _____ Religion: _____
First Middle Last

<u>Birth</u> Mother: _____ Religion: _____
First Middle <u>Maiden</u>

<u>Step</u> - Parent: _____ Religion: _____
First Middle Last

Student Sacramental Information:

Date of Birth: _____ Place of Birth: _____

Baptism: Date: _____ Church: _____ Address: _____

☐ Baptismal Certificate Attached.

Note: Baptismal Certificate required, if not Baptized at St. Ignatius.

Penance:
Date Received: _____ Church: _____ City, State: _____

Communion:
Date Received: _____ Church: _____ City, State: _____

Confirmation:
Date Received: _____ Church: _____ City, State: _____

H511.336 (Rev. 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip Code

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other _____					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health

☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. _____ Date

Result of Diagnostic Studies: _____ Date .

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes _____ Date

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
Print Name of Examiner

_____
Address

_____
Telephone Number

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ____

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

REPORT OF EXAMINATION

TOOTH CHART

		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																	Upper
	LOWER																	Lower

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental/Examiner

_____
Print Name of Dental Examiner

_____
Address

AUTHORIZATION FOR USE OF PHOTOGRAPH/VIDEO/IMAGE

Family Name _____

Name of Child _____ Age _____ Homeroom _____ Gender _____

Name of Child _____ Age _____ Homeroom _____ Gender _____

Name of Child _____ Age _____ Homeroom _____ Gender _____

Name of Child _____ Age _____ Homeroom _____ Gender _____

Name of Child _____ Age _____ Homeroom _____ Gender _____

I/we, the undersigned, hereby consent to the use of any video tapes, photographs, slides, audio tapes or any other audio or visual reproduction in which the above named individual may appear by St. Ignatius Loyola Regional School/Parish and the Diocese of Allentown. I understand that these materials may be used for promotional purposes including recruitment and fund-raising efforts or general publication. Promotion may include, but is not limited to, slide presentations, photo displays, internet promotions, electronic multi-media or billboard display.

I agree that the photograph/image shall be free for use, and release St. Ignatius Loyola Regional School/Parish and the Diocese of Allentown, its employees, volunteers and agents for any liability connected with the use of said photograph or image.

Parent/Guardian Signature _____

Date _____

Address _____

_____