DATE ____________
TIME ____________
AMOUNT __________
FOR OFFICE USE ONLY

2012 FOR THOSE REGISTERING NEW TO THE CHEVERUS SCHOOL 2013

NAME____
LAST FIRST MIDDLE

ADDRESS____
STREET CITY ZIP CODE HOME PHONE

EMAIL1__________________________ EMAIL2__________________________

DATE OF BIRTH_____________________ PLACE OF BIRTH _____________________

LANGUAGE________________ NATIONALITY________________ ETHNICITY________________

RELIGION_____________CHURCH ATTENDING____________________ CITY______________

DATE OF BAPTISM ______________ CHURCH____________________ CITY______________

DATE 1ST COMMUNION____________ CHURCH____________________ CITY______________

FATHER'S FIRST AND LAST NAME____

FATHER'S RESIDENCE_________________________________CELL PHONE______________

FATHER'S OCCUPATION________________________________WORK PHONE______________

FATHER'S EMPLOYER____

FATHER'S RELIGION____________________PLACE OF BIRTH_______________________

MOTHER'S FIRST AND LAST NAME__________________________MAIDEN NAME______________

MOTHER'S RESIDENCE_________________________________CELL PHONE______________

MOTHER'S OCCUPATION________________________________WORK PHONE______________

MOTHER'S EMPLOYER____

MOTHER'S RELIGION____________________PLACE OF BIRTH_______________________

DATE OF REGISTRATION_________________DATE OF ADMISSION_____________________

CHILD/CHILDREN ATTENDING CHEVERUS SCHOOL____________ ______________ ______________

GRADE(S) 2012 –2013 ____________ ______________ ______________

CHILDREN ENTERING KINDERGARTEN MUST BE 5 YEARS OLD BY OCTOBER 31ST OF THAT SCHOOL YEAR

1.) Has your child ever had a Core Evaluation? Yes_______ No_______
2.) Has a Core Evaluation ever been recommended for your child? Yes_______ No_______
3.) Have you ever requested a Core Evaluation for your child? Yes_______ No_______

If your child has been tested, a copy of the education plan is required prior to acceptance.

CHEVERUS SCHOOL

A Superior Education.

PLEASE TELL US HOW YOU LEARNED ABOUT OUR SCHOOL (CHECK ALL THAT APPLY)

____________ radio advertisement
____________ television commercials
____________ parent of a student currently enrolled
____________ parent of a graduate of the school
____________ neighbor
____________ friend or relative
____________ student
____________ on-line access/internet (Web sites)
____________ at church (bulletin, talks by pastor/priest)
____________ billboard
____________ school brochure
____________ newspaper article/advertisement
____________ real estate agent
____________ direct mailing
____________ other

A Catholic Education Is An Advantage For Life

<u>IN ORDER TO REGISTER YOUR CHILD YOU MUST BRING WITH YOU:</u>

1. Birth Certificate
2. Baptismal Record (if applicable)
3. Health Records – including:
    a. Immunization records with a documented result of a lead test
    b. Physical form completed between 1/9 – 9/9 of the current year
4. Report card
5. $200.00 Registration Fee Per Family (NON-REFUNDABLE)

NO CHILD WILL BE CONSIDERED REGISTERED UNLESS ALL MATERIAL IS COMPLETED.

_____ Copy of a signed release form showing that records will be sent from prior school.

Transferred from:____

SCREENING INFORMATION

Screening of children entering Kindergarten consists of a short interview and a short test indicating the child's readiness for school.

IMMUNIZATION REQUIREMENTS

THE STATE LAW CHAPTER 76, SECTION 15, INDICATES THAT NO CHILD SHOULD BE ADMITTED TO SCHOOL UNLESS HE OR SHE HAS BEEN IMMUNIZED AGAINST DIPHTHERIA, TETANUS, PERTUSSIS, MEASLES, MUMPS, RUBELLA, POLIO, HEPATITIS B AND VARICELA EXCEPT FOR MEDICAL OR RELIGIOUS REASONS. Parents must present dates of immunization. Parents should bring documentation from their child's pediatrician. Immunization inoculations may be obtained prior to registration from private physicians or by appointment from the Board of Health Clinic.

RELIGIOUS REQUIREMENTS FOR NON-CATHOLIC STUDENTS

Since Cheverus School is a Catholic School, religion is a major academic subject. Non-Catholic students are required to fulfill the following requirements:

- Participate and successfully complete the Religion course with a passing grade for each grade level as scheduled in the curriculum.
- Attend and participate in all religious programs and other related experiences. This includes all school liturgies, the Christmas Pageant and any other related programs.

_____________________________________ ______________

Parent or Guardian Signature Date

CHEVERUS SCHOOL

A Superior Education.

REQUEST FOR RECORDS

In accordance with the provision of Public Law 93-380 and Massachusetts Law HR 16900, I, as a parent or guardian, hereby authorize the transfer of my child's school records as indicated.

TO: Cheverus School of Sacred Hearts Parish
30 Irving Street
Malden, MA 02148

FROM: ______________________________________
____
____

as soon thereafter as this request is received. Thank you.

Dear Principal:

This is to inform you that _________________________________ has entered the Cheverus School as a___________ grade student. Would you kindly forward the following information at your earliest convenience.

PLEASE CHECK ALL THE FOLLOWING:

_____________ TRANSFER CARD

_____________ HEALTH RECORDS

_____________ DATE OF REQUEST

_____________ TRANSCRIPT OF GRADES

_____________ STANDARDIZED TEST SCORES

_____________ CORE EVALUATIONS OR SPECIAL TESTS

Thank you for your cooperation.

****

AUTHORIZATION FOR RELEASE OF INFORMATION

Date _____________________

I hereby give my permission that all school records of ____________________________ be transferred to the above-named school.

____
Parent or Guardian Signature

____
Telephone Number

____
Address

____
City/Town State Zip Code

INFORMATION FOR SCHOOL HEALTH RECORD

Child's Name______________________________ Sex ______ Date of Birth________________

Street _________________________________City______________Telephone______________

Birthplace ____

Father's Name __________________________Occupation______________________________

Address of Place of Employment ___________________________ Telephone_______________

Mother's Name _________________________ Occupation _____________________________

Address of Place of Employment ___________________________ Telephone ______________

Name of Family Doctor __________________________________ Telephone ______________

Name of Family Dentist __________________________________Telephone ______________

Name, address and telephone number of responsible person who could be called in case of illness at school and no one at home.

Name _______________________Address ___________________Telephone ______________

Other Members of Household:

Name Relation Date of Birth School

____

____

____

Specific Illnesses: Please state all diseases and operations (incl. childhood, etc.) that your child has had; with dates.

____

____

Is your child on any medication? (State type, amount and when given)

____

____

Does your child have any allergies, medical or emotional problems? Give details:

____

____

Does your child have a vision problem? ____

Does your child have a hearing problem? ____

Name and Address of School Last Attended by your Child:

Name ______________________Address ____________________ Telephone ______________

Comments: ____

____

KINDERGARTEN STUDENTS: ATTACH DOCTOR'S CERTIFICATE OF IMMUNIZATION

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name ____ ☐ Male ☐ Female Date of Birth:___________________

Medical History ____

____

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications ____________________ Food ________________ Other ______________

History of Anaphylaxis to __________________ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: ____

☐ ☐ Other (*Please specify*) ____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**___________________________

Hgt: ________(_____%) Wgt:_________(_____%) BMI: _________(_____%) BP: ________

(Check = Normal / If abnormal, please describe.)

☐ General ________________	☐ Lungs __________________	☐ Extremities _____________
☐ Skin __________________	☐ Heart __________________	☐ Neurologic _____________
☐ HEENT _______________	☐ Abdomen _______________	☐ Other __________________
☐ Dental/Oral ____________	☐ Genitalia _______________	

Screening:

	(Pass)	(Fail)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead _______ Date _______________ ☐ Other____________________________________

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: ____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

____ ______________________________________

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

____

Group Practice Telephone

____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name:

Date of Birth: / / **Sex:** ☐ **female** ☐ **male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature:

Facility name: