



CHEVERUS SCHOOL
 SACRED HEARTS PARISH
 30 Irving Street
 Malden, MA 02148
 Ph: (781) 324-6584
 www.cheverusschool.com

DATE _____
TIME _____
AMOUNT _____
FOR OFFICE USE ONLY

2010 FOR THOSE REGISTERING NEW TO THE CHEVERUS SCHOOL 2011

NAME _____
 LAST FIRST MIDDLE

ADDRESS _____
 STREET CITY TELEPHONE

EMAIL _____ CELL PHONE _____

HOME LANGUAGE _____ NATIONALITY _____ ETHNICITY _____

CHURCH NOW ATTENDING _____ PARISH ENVELOPE NO. _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

DATE OF BAPTISM _____ CHURCH _____ CITY _____

DATE OF 1ST COMMUNION _____ CHURCH _____ CITY _____

FATHER'S FIRST AND LAST NAME _____

PLACE OF BIRTH _____

FATHER'S RESIDENCE _____ TELEPHONE NO. _____

FATHER'S OCCUPATION _____ EMPLOYER _____

BUSINESS TEL. NO. _____ FATHER'S RELIGION _____

MOTHER'S FIRST AND LAST NAME _____ MAIDEN NAME _____

PLACE OF BIRTH _____

MOTHER'S RESIDENCE _____ TELEPHONE NO. _____

MOTHER'S OCCUPATION _____ EMPLOYER _____

BUSINESS TEL. NO. _____ MOTHER'S RELIGION _____

DATE OF REGISTRATION _____ DATE OF ADMISSION _____

CHILD/CHILDREN ATTENDING CHEVERUS SCHOOL _____

GRADE(S) – 2010 – 2011 _____

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
SACRED HEARTS PARISH
30 Irving Street
Malden, MA 02148
Ph : (781) 324-6584
www.cheverusschool.com

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

- | | |
|-------|--|
| _____ | radio advertisement |
| _____ | television commercials |
| _____ | a parent of a student currently enrolled |
| _____ | a parent of a graduate of the school |
| _____ | a neighbor |
| _____ | a friend or relative |
| _____ | a 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.

IN ORDER TO REGISTER YOUR CHILD YOU MUST BRING WITH YOU:

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.

_____ A 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’s Signature

Date

INFORMATION FOR SCHOOL HEALTH RECORD

Child's Name _____ Sex _____ Date of Birth _____

Street _____ City _____ Tel. # _____

Birthplace _____

Father's Name _____ Occupation _____

Address of Place of Employment _____ Tel. # _____

Name of Family Doctor _____ Tel. # _____

Name of Family Dentist _____ Tel. # _____

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 _____ Tel. # _____

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 _____ Tel. # _____

Comments: _____

KINDERGARTEN STUDENTS: ATTACH DOCTOR'S CERTIFICATION 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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

(Pass) (Fail)
Vision: Right Eye
Left Eye
Stereopsis

(Pass) (Fail)
Hearing: Right Ear
Left Ear

(Pass) (Fail)
Postural Screening:
(Scoliosis/Kyphosis/Lordosis)

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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Hepatitis A (HepA)	1	
	6			2	
	7				
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		Other:	3	
	2				
	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
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • 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: _____