ST. JOSEPH'S CATHOLIC SCHOOL

EXCELLENCE IN CATHOLIC EDUCATION

Preschool Only: Mark With **X**	AM = 5 days/week
	PM = 4 days/week Mon, Tues, Thurs. Fri

NEW Montessori Preschool – 8th Grade Student Registration Form 2017-2018

Grade Entering ___________

Student ID#_____________

(PLEASE PRINT)

Student's First Name ______________________ Middle _______________ Last _________________

Age _______ Male/Female Date of Birth ____________ Place of Birth _____________________

Religion ____________________ Parish ____

Sacraments received: Baptism ________ Eucharist ________ Confirmation ________

Applied for Financial Aid? ________________________ **Date Submitted:** ____________________

Student lives with: (X) Parents _____ Mother _____ Father _____ Guardian _____

☐ BLACK ☐ ASIAN ☐ WHITE ☐ HISPANIC ☐ AMERICAN INDIAN

(Optional, however this information is used for accurate National Catholic Education Assoc. and State Dept. of Education reports)

The racial/ethnic classifications and definitions are defined by the U.S. Department of Education, Office of Civil Rights. Other designations cannot be accepted. Each student should be identified using only one of the following five categories.
BLACK – Not of Hispanic Origin (A person having origins in any of the black racial groups.
ASIAN or **PACIFIC ISLANDER** – (A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example: China, Japan, Korea, the Philippine Islands, and Samoa)
AMERICAN INDIAN – (A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition)
HISPANIC – (A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race)
WHITE – (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East)

Father/Guardian First: Last:	Mother/Guardian First: Last:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone: Cell:	Phone: Cell:
Email:	Email:
Religion:	Religion:
Parish/Church:	Parish/Church:
Occupation:	Occupation:
Employer:	Employer:

FOR OFFICE USE ONLY

☐ Registration Form Complete
☐ Registration Fee Paid SJS
☐ Smart Tuition Complete
☐ Financial Aid Application (if necessary)
☐ Immunization Current/Received
☐ Commitment Contract

ST. JOSEPH'S CATHOLIC SCHOOL
MEDICAL HISTORY FORM

Student Name: ____ Age: _______ Date of Birth: __________

Mother's Telephone# _________________________ Mother's Cell# _________________________

Father's Telephone# _________________________ Father's Cell# _________________________

____
Parent/Guardian (*Please print*)

HISTORY	**YES**	**NO**
1. Is your student under a doctor's care now?	______	______
2. Are any medications or drugs being taken now?	______	______
If *YES*, please list medication(s): ____		
3. Any allergies to: Bee Stings/Medications/Foods etc..?	______	______
If *YES*, please list type of allergy and severity: __________________________		
4. Are there vision problems: Glasses/Contact Lenses?	______	______
If *YES*, please list vision problem: ______________________________________		
5. Are there or have there been any medical conditions we should know about?	______	______
If *YES*, please list medical condition: ____________________________________		
6. Has your child had any major medical illnesses: Seizures/Diabetes etc..?	______	______
If *YES*, please list medical illness: ______________________________________		
7. Have there been any operations or surgeries?	______	______
8. History of head trauma or repeated concussions?	______	______
9. Been in the hospital in the past year?	______	______

Please explain any "Yes" answers on the above questions. Are there any further instructions or treatment required by the school personnel?

____

____

____ ______________________
Signature of Parent/Guardian Date

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ☐ Yes ☐ No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY): **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ☐ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ☐ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV, MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

☐ a verified history of Varicella (Chickenpox).

☐ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

☐ Diphtheria	☐ Mumps	☐ Other:
☐ Hepatitis A	☐ Polio	
☐ Hepatitis B	☐ Rubella	
☐ Hib	☐ Tetanus	
☐ Measles	☐ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name