New Students Registering at Visitation

Name: _____

Date of Registration: _____

Child's Birthday (Month, Day, Year)

_____

Name of School last attended:

_____

Phone number of school: _____

Grade your child last completed at this school _____

Final grade in June in a letter or number:

Reading: _____
Math: _____

Did your child receive any extra support services at your school? (Check all that apply)

Reading____ Math_____ Speech_____ English as a second language (ESOL)___Counseling____

Are there any extra concerns that we should know about your child?

_____
_____
_____
_____
_____
_____
_____
_____

Information Taken By: _____

VISITATION BVM SCHOOL
300 E. LEHIGH AVENUE
PHILADELPHIA, PA 19125

LAST NAME:_____ FIRST:_____ MIDDLE:_____

ADDRESS:_____ ZIP CODE:_____

HOME PHONE:_____ DATE OF BIRTH:_____ PLACE OF BIRTH:_____

CELL PHONE:_____ SEX: M____ F_____ GRADE:_____ RELIGION:_____

EMAIL ADDRESS:_____

SACRAMENTS

CHURCH WHERE BAPTIZED:_____ DATE:_____ VER.:_____

CHURCH OF COMMUNION:_____ DATE:_____ VER:_____

CHURCH OF CONFIRMATION:_____ DATE:_____ VER.:_____

FAMILY INFORMATION

FATHER'S FULL NAME:_____ RELIGION:_____

FATHER'S ADDRESS:_____ PLACE OF BIRTH:_____

MOTHER'S FULL NAME:_____ RELIGION:_____

MOTHER'S ADDRESS:_____ PLACE OF BIRTH:_____

FATHER'S WORK NUMBER:_____ MOTHER'S WORK NUMBER:_____

LANGUAGE SPOKEN AT HOME:_____

PARENT'S MARITAL STATUS: ___ MARRIED___DIVORCED___WIDOWED___ NOT MARIED___LIVING TOGETHER

IF EITHER PARENT HAS REMARRIED, WHO HAS CUSTODY? MOTHER:_____ FATHER:_____

NAME OF PARENT WHO HAS CUSTODY:_____

IF EITHER PARENT IS REMARRIED, FULL NAME OF:

STEPMOTHER:_____ RELIGION:_____

STEPFATHER:_____ RELIGION:_____

IF SOMEONE OTHER THAN A PARENT HAS CUSTODY:

NAME OF CUSTODIAN:_____ RELATIONSHIP_____

ETHNIC BACKGROUND

ASIAN: _____ BLACK:_____ CAUCASIAN:_____ HISPANIC:_____ OTHER:_____

PARISHIONER:_____ NON PARISHIONER_____

***A Parishioner is a person who is registered in Visitation Parish and uses envelopes to support the Church.*

OVER

ACADEMIC INFORMATION

SCHOOL TRANSFERRED FROM:_____

TRANSFER RECEIVED:_____DATE OF TRANSFER:_____

MEDICAL INFORMATION

DOES YOUR CHILD/CHILDREN HAVE ANY MEDICAL CONDITIONS? YES____ NO____

PLEASE EXPLAIN:_____

MEDICAL INFORMATION COMPLETE:_____

1. PHYSICAL:_____
2. IMMUNIZATION:_____

REGISTRATION FEE PAID:_____

ADVANCE TUITION PAID:_____

TOTAL NUMBER OF CHIDREN IN SCHOOL:_____

TOTAL NUMBER OF CHILDREN IN FAMILY:_____

***PLEASE NOTE : THE REGISTRATION FEE IN NOT REFUNDABLE

VISITATION BVM SCHOOL
300 E. LEHIGH AVENUE
PHILADELPHIA, PA 19125
215.634.7280

Dear Parents/Guardians:

State Legislation authorizes the loan of textbooks and instructional materials by the Secretary of Education to children enrolled in Kindergarten through grade twelve (12) in non-public schools. Our school is now in the process of requesting the specific textbooks and materials to be loaned to your child/children.

It is required however, that a parent of each child attending the non-public school individually requests a loan of textbooks and instructional materials. We are therefore, enclosing the individual request form. Please sign the form, date it and return it to school immediately,

Thank you for your continued assistance and cooperation.

Sincerely,

VISITATION BVM SCHOOL

Edward Coleman

Edward Coleman,
Principal

CERTIFICATE OF INDIVIDUAL REQUEST
FOR LOAN TEXTBOOKS
AND INSTRUCTIONAL MATERIALS

I hereby request the loan of textbooks and instructional materials in accordance with the Pennsylvania School Code of 1949 for my child/children attending Visitation BVM School

Date:_____ Parent/Guardian:_____

VISITATION BVM SCHOOL
300 E. LEHIGH AVENUE
PHILADELPHIA, PA 19125
(215) 634-7280

AGREEMENT FOR ADMISSION

It is our (my) wish that our (my) child (children) attend Visitation BVM Parish Elementary School. We (I) understand that Visitation BVM School is a Catholic School. I (we) understand that my (our) child/children will be taught Religion and fulfill the requirements for this subject and also to attend all religious functions offered as part of the school program.

We (I) assume the obligation to pay the specified tuition and school fees and agree to support the philosophy, goals and regulations of the school.

_____ _____

(School Official) (Date)

_____ _____

(Parent/Guardian) (Date)

VISITATION BVM SCHOOL
300 E. LEHIGH AVENUE
PHILADELPHIA, PA 19125
215.634.7280
www.friendsofvisitation.org

PHOTO RELEASE FORM

I, _____, hereby give the Archdiocese of Philadelphia, its successors and assigns and those acting with its authority, the unqualified right and permission to reproduce, copyright, publish, circulate or otherwise use any school pictures of my child produced by the Archdiocese of Philadelphia. This authorization and release covers the use of said school pictures in any published form and any media of advertising publicity.

I also understand that our school may be identified by name and I fully understand that this is a complete release of all claims against the Archdiocese of Philadelphia or any other person, firm or corporation by reason of any such use of such school pictures.

I hereby warrant that I am free to give this permission. I further warrant that the information I have provided is, to the best of my knowledge true and accurate.

Signature of Parent(s)/Guardians(s) Date

Student Date of Birth

Address

City, State, Zip

Phone School Year

Student Internet Access Contract

I understand that when I am using the Internet or any other computer/telecommunications device, I must adhere to all rules of courtesy, etiquette and laws regarding the copying of information as prescribed by either Federal, State or local laws and the Archdiocese of Philadelphia and Visitation BVM School.

My signature below and that of my parent(s) or guardian(s) means that I agree to follow the guidelines of this *Acceptable Use Policy for Technology for the Catholic Schools of the Archdiocese of Philadelphia.*

*Student Name/ID*_____

*Student Signature*_____

Date_____/_____/_____

Parent or Guardian: We ask that you review this policy with your child and sign below:

Student Access Contract

I hereby release Visitation BVM School and the Archdiocese of Philadelphia, its personnel and any other institutions with which it is affiliated, from any and all claims and damages of any nature arising from my child's use of, or inability to use, the Internet Access, including but not limited to claims that may arise from the unauthorized use of the system to purchase products or services.

I will instruct my child regarding any restrictions against accessing materials that as outlined by the Acceptable *Use Policy for Technology for the Catholic Schools of the Archdiocese of Philadelphia.* I will emphasize to my child the importance of following rules for personal safety. As the parent or guardian of this student, I have read the *Acceptable Use Policy for Technology for the Catholic Schools of the Archdiocese of Philadelphia* for Visitation BVM School. I hereby give my permission for my child to use the Internet and will not hold Visitation BVM School or the Archdiocese of Philadelphia liable as a result of my daughter's/son's use of the Internet on school premises. I understand that my child has agreed not to access inappropriate material on the Internet. If my child accesses inappropriate material on the Internet, all computer privileges will be suspended for one (1) full week.

*Parent/Guardian Signature*_____

*Date*_____/_____/_____

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade

Name of School	Room/Section/Book	Date Issued

TO THE CARE PROVIDER (Please complete all Items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below.

VACCINE	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN DOSES				
Diptheria and Tetanus* (DTap, DTP, Td or DT)	1. / /	2. / /	3. / /	4. / /	5. / /
Polio, (OPV or IPV)	1. / /	2. / /	3. / /	4. / /	
Hepatitis B	1. / /	2. / /	3. / /		
Measles** - Mumps - Rubella (MMR)	1. / /	2. / /	or Measles Serology: Date _____ Titer _____		
Varicella	1. / /	2. / /	Rubella Serology: Date _____ Titer _____		
Other	1. / /	2. / /	Mumps disease diagnosed by a physician: Date _____		

■ Date of last Tetanus Booster_____ ■ Date of last PPD_____ Result_____mm

* One dose must be on or after the fourth (4th) birthday.
** First dose must be on or after the first (1st) birthday and the second dose should be at least one month after the first dose

Does this student have health insurance? ___ Yes ___ No

Name of Insurance Provider:_____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____
2. Audiometric Screening: R_____ L_____ 3. BP_____
4. Height _____inches / cm Weight _____lb. / kg BMI percentile _____
5. Scoliosis Screening: ____ Normal ____ Abnormal ____ Referred ____ No Referral
6. Activity Recommendation: ____ Full Physical Activity ____ Restricted Physical Activity
   (Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions: _____
7. List all medications currently being taken:
   Medication:_____ Reason:_____
8. List ALL problems by history or examination: Circle status of problem
   1. _____ Under Care Care Complete Referred
   2. _____ Under Care Care Complete Referred
   3. _____ Under Care Care Complete Referred

   ____ No Problems Identified

Comments / follow-up treatment plan / Special Instructions to school:

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

THE SCHOOL DISTRICT OF PHILADELPHIA

PUPIL MEDICAL HISTORY

NAME OF SCHOOL	CLUSTER	DATE
NAME OF STUDENT	RM/BK/SEC	GRADE

DEAR PARENT/GUARDIAN:

PENNSYLVANIA LAW REQUIRES THAT ALL CHILDREN MUST HAVE A COMPLETE CHECK-UP WHEN ENTERING SCHOOL FOR THE FIRST TIME AND AGAIN IN MIDDLE AND HIGH SCHOOL.

YOUR FAMILY DOCTOR IS THE BEST PERSON TO DO THIS CHECK-UP AND PROVIDE ALL NECESSARY HEALTH CARE. IF YOU WOULD LIKE SOME HELP FINDING A FAMILY DOCTOR OR CLINIC, OR IF YOU HAVE OTHER CONCERNS ABOUT YOUR CHILD'S HEALTH, PLEASE CALL THE SCHOOL NURSE AT _____.

THE SCHOOL NURSE CAN ALSO HELP YOU WITH INFORMATION REGARDING HEALTH INSURANCE. THERE ARE FREE AND LOW COST INSURANCE PLANS FOR WHICH YOUR FAMILY MAY QUALIFY. THERE IS NO REASON FOR ANY CHILD IN PHILADELPHIA TO BE WITHOUT HEALTH CARE.

YOUR COOPERATION IS VERY IMPORTANT TO US. PLEASE TAKE THE ATTACHED FORM TO YOUR DOCTOR OR CLINIC WHEN YOU TAKE YOUR CHILD FOR THIS CHECK-UP AND RETURN THE COMPLETED FORM TO THE SCHOOL NURSE BY _____.

SINCERELY,

PRINCIPAL:	SCHOOL NURSE:

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. DO YOU HAVE HEALTH INSURANCE ? ☐ YES ☐ NO

   WHAT IS THE NAME OF YOUR HEALTH INSURANCE ? _____

2. WHERE DO YOU TAKE YOUR CHILD FOR CHECK UPS ? _____

3. DATE OF CHILD'S LAST PHYSICAL EXAMINATIONS ? _____

4. WHERE DO YOU TAKE YOUR CHILD IN AN EMERGENCY ? _____

5. WHERE DO YOU TAKE YOUR CHILD FOR DENTAL CARE ? _____

6. DATE OF CHILD'S LAST DENTAL EXAMINATIONS ? _____

7. WHAT MEDICINE IS YOUR CHILD NOW TAKING ? _____ HOW OFTEN _____ WHAT IS IF FOR _____

8. IS YOUR CHILD ALLERGIC TO ANY MEDICINE? ☐ YES ☐ NO IF YES, WHAT MEDICINE _____

9. NUMBER OF PERSONS LIVING IN SAME HOME AS YOUR CHILD? _____ ADULTS _____ CHILDREN

10. DO YOU WISH TO DISCUSS ANYTHING ABOUT YOUR CHILD'S HEALTH WITH THE SCHOOL / NURSE ? ☐ YES ☐ NO

(USE OTHER SIDE FOR COMMENTS)

CHECK ANY PROBLEM YOUR CHILD OR IMMEDIATE FAMILY MEMBER HAS HAD:

	FAMILY	CHILD
ALCOHOL/DRUG	☐	☐
ALLERGY/ASTHMA	☐	☐
ANEMIA	☐	☐
ARTHRITIS	☐	☐
BEHAVIOR/EMOTIONAL	☐	☐
CANCER	☐	☐
DENTAL	☐	☐
DIABETES	☐	☐

	FAMILY	CHILD
ECZEMA	☐	☐
FREQUENT COLDS	☐	☐
HEARING DIFFICULTY	☐	☐
HEART	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HOSPITALIZED (OPERATIONS)	☐	☐
	☐	☐
	☐	☐

	FAMILY	CHILD
LEARNING PROBLEM	☐	☐
LUNG DISEASE	☐	☐
LEAD POISONING	☐	☐
MENTAL RETARDATION	☐	☐
MULTIPLE HANDICAP	☐	☐
MUSCLE/BONE/JOINT	☐	☐
NERVOUS TROUBLE	☐	☐
OVERWEIGHT	☐	☐

	FAMILY	CHILD
PHYSICAL HANDICAP	☐	☐
PREMATURE BIRTH (UNDER 5 LBS.)	☐	☐
SEIZURES	☐	☐
SPEECH DIFFICULTY	☐	☐
TUBERCULOSIS	☐	☐
VISION PROBLEMS	☐	☐
URINATION/KIDNEY	☐	☐
PROBLEM	☐	☐

CONTAGIOUS DISEASES YOUR CHILD HAS HAD:

	(AGE)
☐ CHICKEN POX	_____
☐ DIPTHERIA	_____
☐ GERMAN MEASLES	_____
☐ MEASLES	_____

	(AGE)
☐ MENINGITIS	_____
☐ MUMPS	_____
☐ PNEUMONIA	_____
☐ POLIOMYELITIS	_____

	(AGE)
☐ RHEUMATIC FEVER	_____
☐ SCARLET FEVER/STREP THROAT	_____
☐ TYPHOID FEVER	_____
☐ WHOOPING COUGH	_____

AGE TALKED _____ AGE WALKED _____ AGE TOILET TRAINED _____

TIRES EASILY ☐ BED WETTING ☐ NIGHTMARES ☐ CONSTIPATION ☐ INADEQUATE SLEEP ☐ POOR APPETITE ☐

WHEN WAS THE LAST TIME YOUR CHILD HAD A TUBERCULIN TEST? _____ RESULTS _____

IS YOUR CHILD IN GOOD HEALTH? ☐ YES ☐ NO