NOTRE DAME DE LOURDES
PRE-KINDERGARTEN REGISTRATION FORM
ACADEMIC YEAR 2018-2019

NON-REFUNDABLE REGISTRATION FEE $100.00
(Checks should be made out to Our Lady of Peace)

FAMILY NAME _____

FATHER'S NAME _____ **MOTHER'S NAME** _____

ADDRESS _____

PHONE: _____ **home** _____ **work**
FATHER **FATHER**

PHONE: _____ **home** _____ **work**
MOTHER **MOTHER**

EMAIL ADDRESS: _____

List names of child/ren entering PRE-KINDERGARTEN 3 in September 2018

_____ **Full Day** **Half Day**

_____ **Full Day** **Half Day**

Please take note of tuition rates:

Pre-Kindergarten 3 (Half Day) is $2850.00
Pre-Kindergarten 3 (Full Day) is $3750.00

I agree to the following:

A) **make monthly payments on the 15th of each month onto Smart Tuition.**
B) **that if my payments are in arrears I understand that my child(ren) will not be permitted to attend class or extracurricular activities until I make arrangements for payment.**
C) **accept the polices and procedures outlined in Notre Dame de Lourdes School's Student/Parent Handbook.**
D) **supervise the scholastic obligations of my child as required by the regulations of Notre Dame de Lourdes School.**
E) **attend Mass weekly if a registered member of the parish.**
F) **understand that all transfer requests and records will be held until tuition is satisfied.**

Parent Signature/s _____ **Date** _____

Notre Dame de Lourdes School

990 Fairview Road • Swarthmore, Pennsylvania 19081 • 610.328.9330 • info@notredamedelourdes.net

Registration Checklist

Student's Name: _____

Grade: _____ School Year: _____

_____ Contract

_____ Registration Form

_____ Loan of Textbooks Form

_____ Agreement for Admission (All Non-Catholic students)

_____ Health History Form

_____ Health Permission Form

_____ Physical Form (All new students K-8)

_____ Dental Form (All new students K-8)

_____ Early Childhood Form (PreK 3, 4 and Kindergarten)

_____ Copy of Immunizations (All new students PreK 3 -8)

_____ Copy of Birth Certificate

_____ Copy of Social Security Card

_____ Copy of Baptismal Certificate

Office use only

_____ Registration Fee Paid Date_____

Check #_____ Cash_____

This is Who We Are: The Neighborhood School with a Big Heart.

ARCHDIOCESE OF PHILADELPHIA-ELEMENTARY SCHOOL PERMANENT RECORD FORM

Notre Dame de Lourdes School

PLEASE PRINT ALL INFORMATION

NOTRE DAME DE LOURDES SCHOOL – REGISTRATION FORM

(Last) (First) (Middle) (Country of Birth) (Date of Birth) (Sex)

(Address) (City) (State) (Zip) (County of Residence) (Phone No.) (School District/ Residence)

SOCIAL SECURITY NUMBER _____ **ARE YOU A REGISTERED MEMBER OF OUR LADY OF PEACE PARISH? N__ Y___**

If no, please specify parish _____

FAMILY BACKGROUND

	FULL NAME	ADDRESS (if different)	PHONE # (if different)	DECEASED (√)	RELIGION	COUNTRY OF BIRTH
Father						
Mother (include maiden name)						
Guardian						

Relationship of guardian to student _____ Please circle one: Contributing Catholic Non Catholic

Home situation (Check all that apply)

- □ Two biological parents
- □ Mother/stepfather
- □ Father/stepmother
- □ One parent
- □ Parents separated or divorced
- □ Other: Specify

Language spoken at home if **not** English _____

Parental rights (in case of separation or divorce)
(A copy of any court papers is requested for your child's file)

Legal Custody: □ Joint Custody □ Sole Custody
Physical Custody: □ Joint Custody □ Sole Custody
□Mother □Father □Guardian
□**No Papers on File**

ARCHDIOCESE OF PHILADELPHIA-ELEMENTARY SCHOOL PERMANENT RECORD FORM

Notre Dame de Lourdes School

SACRAMENTAL INFORMATION

(Any denomination)

	Date	Church	City	State, Zip
Baptism				
First Penance				
First Eucharist				
Confirmation				

Previous school attended_____

Has this student ever been in a Special Education Program NO_____ YES _____

If yes, please name the program_____

Special Education Services were provided by _____

How did you hear of our school? (check all that apply)
My child currently attends____ Neighbor/Relative____ Church Bulletin____ Newspaper Ad____ Signage outside of school _____

Census Information – (Optional)

American Indian _____ Black/American _____
Asian _____ Caucasian _____
Multi-Racial _____ National Hawaiian Pacific Island _____

Signature _____ Date _____

Notre Dame de Lourdes School
990 Fairview Road • Swarthmore, Pennsylvania 19081

Dear Parent/Guardian:

State legislation authorizes the loan of textbooks, instructional material and equipment by the Secretary of Education to Pennsylvania children enrolled in kindergarten through grade 12 in nonpublic and private schools. Our school is now in the process of requesting specific textbooks, materials and equipment to be loaned to your child(ren). It is required, however, that a parent/guardian of each child attending the non public or private school individually request a loan of textbooks, instructional materials and equipment. 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.

Very truly yours,

Mrs. Susan B. Lowe
Principal

CERTIFICATE OF INDIVIDUAL REQUEST
FOR LOAN OF 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(ren) attending Notre Dame de Lourdes School.

Student Name _____
(Please Print)

Date: _____ (Signed) _____
Parent/Guardian Signature

This program is available only to Pennsylvania residents.
(This form is to remain on file at the school.)

Notre Dame de Lourdes School
990 Fairview Road • Swarthmore, Pennsylvania 19081

Agreement for Admission

Family Name_____
PLEASE PRINT

It is our (my) wish that our (my) child (children) attend **Notre Dame de Lourdes School.** We (I) understand that our (my) child (children) is (are) obligated to attend classes in Religion and fulfill the requirements for this subject; 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, objectives, and regulations of the school.

Mother's Signature_____
DATE

Father's Signature_____
DATE

RIDLEY SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
901 MORTON AVENUE,
FOLSOM, PENNSYLVANIA 19033
(610) 534-1900 EXT. 1255
(610) 534-2335 FAX

HEALTH HISTORY

Child's Name _____ Date of Birth _____

Street Address _____ Home Phone (Area Code) _____

City, State, Zip _____

Father's Name _____ Work Phone (Area Code) _____
Cell phone (Area Code) _____
E-mail address _____

Mother's Full Maiden Name _____ Work Phone (Area Code) _____
Cell phone (Area Code) _____
e-mail address: _____

Do parents live together? Yes or No

Adults with whom child lives (if other than parents): _____

Were there any significant pre-natal or birth factors such as RH factor, pre-maturity? Yes or No
If yes, indicate the factor(s) _____

Does Your Child Have:	Please Circle		Has Your Child Had:	Please Circle	
Frequent colds	yes	no	A blood transfusion	yes	no
Frequent sore throats	yes	no	Tonsillectomy/Adenoidectomy	yes	no
Diabetes	yes	no	Head injury (unconscious)	yes	no
Asthma	yes	no	Convulsions/seizures	yes	no
Speech problem	yes	no	Chicken Pox	yes	no
Earaches	yes	no	Scarlet Fever	yes	no
Frequent nightmares	yes	no	Tuberculosis (self/family)	yes	no
Vision loss	yes	no	Rheumatic Fever	yes	no
Hearing loss	yes	no	Pneumonia	yes	no
Poor eating habits	yes	no	Hepatitis	yes	no
Emotional problems	yes	no	Heart problem	yes	no
Enuresis (bedwetting)	yes	no	Epilepsy or other seizure disorder	yes	no
Difficulty sleeping	yes	no			
Allergies (list)	yes	no			

_____
_____

Developmental Patterns:

Did your child crawl? yes no
Is your child on medication? yes no
Does your child stumble, fall or bump into things frequently? yes no
Age child talked (words) ____yrs.____ months
Age child walked ____yrs.____ months

Is your child presently under medical treatment? yes no
If yes, indicate the reason _____
Is your child easily understood by others? yes no
Age child spoke (sentences) ____yrs.____ months

Please comment below on any "yes" answers from above. Also list hospitalizations, surgeries, serious accidents, or other illnesses or conditions, which you feel that the school should know. All information will remain confidential except in cases where the classroom teacher would need to know about a student's medical condition for the benefit of the student

_____
_____

Parent Signature _____ Parent name (printed) _____ Date _____

It is the mission of the Ridley School District to create a caring environment that gives all students the opportunity to achieve their fullest personal and academic potential in order to become productive and responsible citizens.

RIDLEY SCHOOL DISTRICT

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HEALTH HISTORY PERMISSION FORM (INITIAL HISTORY)

STUDENT NAME _____ GRADE ____ DATE _____

THE NATURE OF THIS HEALTH HISTORY

I understand that the information I give to the School Nurse is important for the school staff to know and that it will help them to promote the health and education of my child. I understand that the information will be kept confidential by the school Health Staff, and will be shared with other professionals in the school only when the School Nurse/Nurse Practitioner/School Physician believes that it is in the best interest of my child's health and education.

Copies of this health history will be sent to other agencies that request it only with my written permission.

Signature of Parent/Guardian _____ DATE _____

Name of Parent/Guardian (printed) _____

EXPLANATION OF HEALTH SERVICES

The following health services are provided to every student in the Ridley School District in compliance with Pennsylvania State Law:

Every year every student:	Height, weight, vision screening, BMI
K, 1, 2,3, 7 and 11th Grade:	Hearing screening
K, 1, 3, and 7th Grade:	Dental-by school/family dentist
K or 1, 6, and 11th Grade	Physical-by school/family doctor
6th and 7th Grade:	Scoliosis screening

I understand the above screening and examination results will become a part of my child's permanent health record.

Signature of Parent/Guardian _____ DATE _____

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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 _____.

Result of Diagnostic Studies: _____.
Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ No ☐ Yes _____ Date

Significant Medical Conditions (√)
If Yes, Explain

	Yes	No	
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 Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
PRINT Name of Examiner

_____
Address

_____
Telephone Number

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DENTAL EXAMINATION

The Pennsylvania School Health Law requires dental examinations for children--one upon entrance into school, one in third grade, and one in seventh grade. These grades were selected because they represent critical periods of growth and development in a child's life. We recommend you take your child to your private dentist before **Jan. 1** and return the following form to the school nurse. **If the school nurse or dental hygienist in the building where your child attends school has not received the completed form by Jan. 1st**, the school dentist or dental hygienist will schedule your child for a dental examination.
Your interest and cooperation is appreciated.

_____ School Nurse _____ Telephone _____ e-mail

FAMILY DENTIST REPORT

School District: Ridley County: Delaware

Name of child: _____ (last name) (first name) Date of birth: _____ (month – day – year) Sex: M or F

Home Address: _____ City _____ State _____ Zip _____

The above named child last visited my office on _____ (month – day – year)

At that time, all necessary dental corrections had been made. Yes No

If the answer is No, complete the following:

This child is in need of treatment for one or more of the following:

Primary Teeth _____ Fillings _____ Extractions _____

Permanent Teeth _____ Fillings _____ Extractions _____

Cleft Palate and/or Cleft Lip _____

Other Congenital Malformations _____

Diseases of the supporting tissues _____

Prosthetic Replacements for Lost or Missing Teeth _____

Gross Malocclusion, which is producing a facial deformity or is interfering with function _____

This child is currently under treatment: (circle) Yes No

Signature of dentist _____ D.D.S. Date _____

Address: _____ City _____ State _____ Zip _____

Phone number: _____ Fax number: _____

Student's grade _____ Homeroom teacher _____

It is the mission of the Ridley School District to create a caring environment that gives all students the opportunity to achieve their fullest personal and academic potential in order to become productive and responsible citizens.

Early Childhood Information Sheet

Pre K & Kindergarten

Child's Name _____

Date of Birth _____ Home Phone # _____

Address _____

_____

Parent's Name _____

1. Has your child attended a Nursery School prior to Notre Dame?
   If so, please name _____
2. Has your child attended a Library Story Hour? _____
3. Is a language other that English spoken at home? _____
4. Does your child have playmates his/her own age? _____
5. Does your child have a hobby or some special interest? _____
6. Does your child have any physical problems that we should be aware of?
   For example, an allergy, hearing, speech or vision problem?

   _____

   _____

   _____
7. Does your child have any fears we should be aware of? _____

   _____

   _____
8. Does your child have an older brother or sister at this school? _____
   If yes, please list the names and grades of the siblings...

   _____

   _____
9. Do you have an occupation, hobby or pastime that you would be willing to share with our children? _____

   _____
10. Please list additional comments or information about your child that you think might be helpful.

    _____

    _____

    _____