HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Checklists

Student Name:_____

Birthdate:_____ **Grade:**_____

Registration Forms and Documents

Forms:

- Registration Form_____
- Student Information Form(s)_____
- Request for Records (transfer from a different school in grades 1-8)_____
- After-School Program Form (K-8) – If applicable_____
- Medical Form_____
- Medication Form – If applicable_____

Documents:

- Birth Certificate_____
- Baptismal Certificate – If applicable_____
- Social Security Card_____
- Updated Immunization Records_____
- Copy of Tax Forms from year prior (Tuition discount)_____

*Non-refundable Registration Fee: $100 per child_____

Records Release Forms

- Grades and/or academic standing_____
- Individual standardized Achievement Test Results_____
- Health Forms_____
- Psychological evaluation report_____
- Key to grading system_____
- Copy of Social Security Card_____
- Copy of Birth Certificate_____
- Copy of Baptismal Certificate – if applicable_____

HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Prospective Student Form

Parent/Guardian Information

Name:_____

Relationship: Father Mother Grandmother Grandfather Guardian Other:_____

Address/City/State/Zip:_____

Email Address:_____

Please provide the best number(s) to reach you:

1._____ Phone Type: Cell Office Home

2._____ Phone Type: Cell Office Home

Name:_____

Relationship: Father Mother Grandmother Grandfather Guardian Other:_____

Address/City/State/Zip:_____

Email Address:_____

Please provide the best number(s) to reach you:

1._____ Phone Type: Cell Office Home

2._____ Phone Type: Cell Office Home

Student Information

1. Name:_____ Date of Birth:_____ Enrolling Grade:____

2. Name:_____ Date of Birth:_____ Enrolling Grade:____

3. Name:_____ Date of Birth:_____ Enrolling Grade:____

4. Name:_____ Date of Birth:_____ Enrolling Grade:____

Is there anything we need to know to better serve your student, for example, special physical or emotional needs, behavioral issues, or health concerns? If so, please list.

_____

_____

_____

_____

HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Registration Form

Parent/Guardian Information #1

Name:_____ Custodial Parent: Yes No

Relationship: Father Mother Grandmother Grandfather Guardian Other:_____

Address/City/State/Zip:_____

Email Address:_____

Please provide the best number(s) to reach you:

1._____ Phone Type: Cell Office Home

2._____ Phone Type: Cell Office Home

Religion:_____ Parish:_____

Highest Education Completed:_____

Employer:_____ Occupation:_____

Marital Status: Single_____Married_____ Separated_____ Divorced_____ Remarried_____

Parent/Guardian Information #2

Name:_____ Custodial Parent: Yes No

Relationship: Father Mother Grandmother Grandfather Guardian Other:_____

Address/City/State/Zip:_____

Email Address:_____

Please provide the best number(s) to reach you:

1._____ Phone Type: Cell Office Home

2._____ Phone Type: Cell Office Home

Religion:_____ Parish:_____

Highest Education Completed:_____

Employer:_____ Occupation:_____

Marital Status: Single_____Married_____ Separated_____ Divorced_____ Remarried_____

Non-Attending Children: Please list any children (up to age 14) who are not currently attending Holy Trinity

Name:_____Birthdate:_____Gender:_____

Name:_____Birthdate:_____Gender:_____

HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Registration Form

Student Information #1

Name:_____

Grade (K-8):_____

Address/City/State/Zip:_____

Phone Number:_____ Public School District:_____

Sex: M_____F_____ Birthdate:_____ Birthplace:_____

Student lives with: Both parents_____Mother_____ Father____Guardian_____Other_____

Race (Mark all that apply) _____American Indian/Alaskan _____Asian _____White

_____Black/African American _____Hispanic/Latino _____Native Hawaiian/Other Pacific Islander

Sacraments:	**Date**	**Church**	**City/State**
Baptism	_____	_____	_____
Reconciliation	_____	_____	_____
Holy Eucharist	_____	_____	_____
Confirmation	_____	_____	_____

Religion:_____ Parish:_____

Health Concerns and Allergies_____

_____

_____

_____

_____

Please return a completed registration form and fee of $100 per student to:
Holy Trinity Catholic School

This fee is non-refundable and will be deducted from your tuition bill.

For Office Use Only: _____ Birth Certificate _____ Baptismal Certificate _____ Social Security Card
_____ Updated Immunization Records _____ Medical Form _____ Tax Forms

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HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Registration Form

Student Information #2

Name:_____

Grade (K-8):_____

Address/City/State/Zip:_____

Phone Number:_____ Public School District:_____

Sex: M_____F_____ Birthdate:_____ Birthplace:_____

Student lives with: Both parents_____Mother_____ Father____Guardian_____Other_____

Race (Mark all that apply) _____American Indian/Alaskan _____Asian _____White

_____Black/African American _____Hispanic/Latino _____Native Hawaiian/Other Pacific Islander

Sacraments:	**Date**	**Church**	**City/State**
Baptism	_____	_____	_____
Reconciliation	_____	_____	_____
Holy Eucharist	_____	_____	_____
Confirmation	_____	_____	_____

Religion:_____ Parish:_____

Health Concerns and Allergies_____

_____

_____

_____

_____

Please return a completed registration form and fee of $100 per student to:
Holy Trinity Catholic School

This fee is non-refundable and will be deducted from your tuition bill.

For Office Use Only: _____ Birth Certificate _____ Baptismal Certificate _____ Social Security Card
_____ Updated Immunization Records _____ Medical Form _____ Tax Forms

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HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Registration Form

Student Information #3

Name:_____

Grade (K-8):_____

Address/City/State/Zip:_____

Phone Number:_____ Public School District:_____

Sex: M_____F_____ Birthdate:_____ Birthplace:_____

Student lives with: Both parents_____Mother_____ Father____Guardian_____Other_____

Race (Mark all that apply) _____American Indian/Alaskan _____Asian _____White

_____Black/African American _____Hispanic/Latino _____Native Hawaiian/Other Pacific Islander

Sacraments:	**Date**	**Church**	**City/State**
Baptism	_____	_____	_____
Reconciliation	_____	_____	_____
Holy Eucharist	_____	_____	_____
Confirmation	_____	_____	_____

Religion:_____ Parish:_____

Health Concerns and Allergies_____

_____

_____

_____

_____

Please return a completed registration form and fee of $100 per student to:
Holy Trinity Catholic School

This fee is non-refundable and will be deducted from your tuition bill.

For Office Use Only: _____ Birth Certificate _____ Baptismal Certificate _____ Social Security Card
_____ Updated Immunization Records _____ Medical Form _____ Tax Forms

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HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Registration Form

Student Information #4

Name:_____

Grade (K-8):_____

Address/City/State/Zip:_____

Phone Number:_____ Public School District:_____

Sex: M_____F_____ Birthdate:_____ Birthplace:_____

Student lives with: Both parents_____Mother_____ Father____Guardian_____Other_____

Race (Mark all that apply) _____American Indian/Alaskan _____Asian _____White

_____Black/African American _____Hispanic/Latino _____Native Hawaiian/Other Pacific Islander

Sacraments:	**Date**	**Church**	**City/State**
Baptism	_____	_____	_____
Reconciliation	_____	_____	_____
Holy Eucharist	_____	_____	_____
Confirmation	_____	_____	_____

Religion:_____ Parish:_____

Health Concerns and Allergies_____

_____

_____

_____

_____

Please return a completed registration form and fee of $100 per student to:
Holy Trinity Catholic School

This fee is non-refundable and will be deducted from your tuition bill.

For Office Use Only: _____ Birth Certificate _____ Baptismal Certificate _____ Social Security Card
_____ Updated Immunization Records _____ Medical Form _____ Tax Forms

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HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Request to Release School Records

Public Law 93-380 (Federal Family Education Rights and Privacy Act of 1974) specifically states that school records may be released to a third party provided that:

1. Written consent is obtained from the parent, guardian, or legal age student.
2. The reason for the release is stated.
3. The identity of the third party is specified.
4. The parents received a copy of the record, if desired.
5. The records to be released are specified.

Date:_____

I, as a parent or guardian of _____ authorize and approve the release of all information concerning the educational placement of my child who is enrolling in grade_____and whose birth date is _____.

Records are in the custody of:

School Name:_____

Address:_____

_____

School Phone: _____

Records will be sent to:

Holy Trinity Catholic School

840 Washington Avenue

Newport, KY 41071

Fax: **859-431-8745**

Information should include:
Grades and/or academic standing
Individual standardized Achievement Test Results
Health Forms
Psychological evaluation report
Key to grading system
Copy of Social Security Card
Copy of Birth Certificate
Copy of Baptismal Certificate – if applicable

My signature below constitutes notice to me that this information will be disclosed only to school personnel who have a legitimate educational interest in my child.

_____
Parent or Guardian Signature

HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Emergency Medical Record

In case of an emergency, we need your child's information listed below. If we cannot get in touch with you, the alternative names will be contacted. Please take the time to fill out this form completely and send it to school as soon as possible. If a phone number or any other information changes through the school year, please call the school or send a note.

Student Name:_____ Grade:_____

Parent/Guardian Information
Name:_____
Relationship: Father Mother Grandmother Grandfather Guardian Other:_____
Address/City/State/Zip:_____
Email Address:_____
Please provide the best number(s) to reach you at during the After-School Program
1._____ Phone Type: Cell Office Home
2._____ Phone Type: Cell Office Home

Name:_____
Relationship: Father Mother Grandmother Grandfather Guardian Other:_____
Address/City/State/Zip:_____
Email Address:_____
Please provide the best number(s) to reach you at during the After-School Program
1._____ Phone Type: Cell Office Home
2._____ Phone Type: Cell Office Home

Alternative Contact (If parent/guardian cannot be reached)
1. Name:_____Phone Number:_____ Relationship:_____
2. Name:_____Phone Number:_____ Relationship:_____
3. Name:_____Phone Number:_____ Relationship:_____
4. Name:_____Phone Number:_____ Relationship:_____

Please list any allergies your child has:_____

_____

If allergic attack requires medicine to be given to your child, you must provide that to the office.

Does your child have any contagious diseases or blood disorders? **YES** **NO** If so, please list:_____

_____

Family Physician Name:_____Phone Number:_____

Do we have permission to send your child to a hospital, should that be necessary?_____

If yes, which hospital?_____

_____

Parents Signature

HOLY TRINITY CATHOLIC SCHOOL

2018-2019
Prescription Drug and Medicine Authorizations Form

*** The following information must be completed before medicine is given. ***

Date:_____

Name of Student:_____

Name of Prescription/Medicine:_____

Prescribing Doctor:_____

Amount of dosage:_____

Times to be given:_____

Additional information needed before administering medicine:_____

_____

_____

I hereby authorize HOLY TRINITY CATHOLIC SCHOOL to dispense medicine as directed.

_____

Parents Signature

COMMONWEALTH OF KENTUCKY
CERTIFICATE OF IMMUNIZATION STATUS

Certificate Issuing Office Name and Address

Name of Child: _____ **Birthdate:** _____
(Last) (First) (Middle) (Suffix) (MM/DD/YYYY)

Name of Parent: _____
(Last) (First) (Middle) (Suffix)

Address: _____
(Street) (City) (State) (Zip Code)

VACCINE	DOSE 1 MM/DD/YYYY	DOSE 2 MM/DD/YYYY	DOSE 3 MM/DD/YYYY	DOSE 4 MM/DD/YYYY	DOSE 5 MM/DD/YYYY
Hepatitis B	/ /	/ /	/ /	/ /	
Alt. Adult Hepatitis B[1]	/ /	/ /			
DTaP/DTP/DT[2]	/ /	/ /	/ /	/ /	/ /
Hib[3]	/ /	/ /	/ /	/ /	
Pneumococcal (PCV13)	/ /	/ /	/ /	/ /	
Polio	/ /	/ /	/ /	/ /	/ /
Influenza	/ /	/ /			
MMR	/ /	/ /			
Varicella	/ /	/ /	**Had Chickenpox or Zoster Disease** **Yes** **No**		/ /
Hepatitis A	/ /	/ /			
Meningococcal	/ /	/ /			
Td	/ /	/ /			
Tdap	/ /	/ /			
Rotavirus	/ /	/ /	/ /		
HPV	/ /	/ /	/ /		
Men B	/ /	/ /	/ /		
Pneumococcal (PPSV23)	/ /	/ /			

[1]Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age. [2]DTaP, DTP, or DT. [3]Hib not required at 5 years of age or more.

☐ This child <u>is current</u> for immunizations until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

☐ This child <u>is not up-to-date</u> at this time. This certificate is valid until ___/___/____, (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

Reason child is not up-to-date:

☐ **Provisional Status** - Child is behind on required immunizations.

☐ **Medical Exemption** - The following immunizations are not medically indicated: _____

_____

If Medical Exemption, can these vaccines be administered at a later date? **No:** _____ **Yes:** _____ **Date:** ___/___/___

☐ **Religious Objection**

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.

_____ _____
(Signature of physician, APRN, PA, pharmacist, LHD administrator, RN or LPN designee) (Date)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky UNBRIDLED SPIRIT

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE INDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ **Gender: M F Grade:** _____

Date of Birth: _____ **Age:** _____ **yrs** _____ **months Preferred Language:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: _____

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

Height: _____ **ft** _____ **inches** _____ **Weight** _____ **BMI:** _____ **BMI%** _____ **B/P:** _____

Vision	**Right 20/_____**	**Passed** ☐ **Failed** ☐ **Referred** ☐	**Hearing – Right**	**Passed** ☐	**Failed** ☐	**Referred** ☐
	Left 20/_____		**Hearing - Left**	**Passed** ☐	**Failed** ☐	**Referred** ☐

Optional: Hct/HGB: _____ **Lead:** _____ **Urinalysis:** _____

Gross dental (teeth and gums)	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Head/scalp/skin	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Eyes/Ears/Nose/Throat	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Chest/Lungs/Heart	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Abdomen	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____
Scoliosis assessment	☐ **Normal**	☐ **Abnormal** _____	**Refer/Tx:** _____

(Over)

This child has the following problems that may impact the educational experience:

☐ **Vision** ☐ **Hearing** ☐ **Speech/Language** ☐ **Physical** ☐ **Social/Behavioral** ☐ **Cognitive**

Specify: _____

_____

☐ **This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.**

_____

Recommendations (Attach additional sheet if necessary): _____

_____

(Please Check One)

☐ **This child may participate fully in school activities including physical education.**

☐ **This child may participate in school activities including physical education with the following restriction/adaptation.**

(Specify reason and restriction) _____

_____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☐ **SCHOOL READINESS**
- **Establish routines**
- **After-school care/activities**
- **Friends**
- **Bullying**
- **Communicate with teachers**

☐ **MENTAL HEALTH**
- **Family time**
- **Anger management**
- **Discipline for teaching not punishment**
- **Limit TV, computer**

☐ **NUTRITION AND PHYSICAL ACTIVITY**
- **Healthy weight**
- **Well-balanced diet, including breakfast**
- **Fruits, vegetables, whole grains, dairy**
- **60 minutes of exercise/day**

☐ **ORAL HEALTH**
- **Regular dentist visits**
- **Brushing/Flossing**
- **Fluoride**

☐ **SAFETY**
- **Sexual safety**
- **Pedestrian safety**
- **Safety helmets**
- **Swimming safety**
- **Fire escape plan**
- **Smoke/carbon monoxide detectors**
- **Guns**
- **Sun**
- **Appropriately restrained in all vehicles**

Additional comments or recommendations: _____

_____

_____

_____

_____

_____

Signed: _____ **Date:** _____

Physician/APRN/PA/EPSDT Provider

Address: _____ **Telephone:** _____