St Joan of Arc

National Blue Ribbon

School

Please include with the registration forms a copy of the child's Baptismal certificate, birth certificate, social security number card, letter of parish registration, immunization records, and a $100 non-refundable fee.

If you have any questions please feel free to contact Deb Rizzotto at 717-533-2854 or by email at

drizzotto@stjoanhershey.org

Diocese of Harrisburg
Permanent Elementary School Record

PLEASE FILL OUT ENTIRE FORM

Pupil ____ Sex ___________________
(Last) (First) (Middle)

Address ____ School District __________________________

City ____________________ State ________ Zip ________ Telephone ______________ E-Mail ____________________

Birth Date (Month) ______ (Day) _____ (Year)_______ SS# ____________________ Place of Birth ____________________

Registered Parish ____ Location _________________________________

Admitted from ____ Date ______________ Grade ___________
(School)
Address ____

	Parish	City/Town & State	Date
Baptism			
First Penance			
First Eucharist			
Confirmation			

	Name	Occupation	Religion	Education (Circle)
Father				Elem. Coll. Sec. Adv.
Mother				Elem. Coll. Sec. Adv.
Guardian	Maiden Name			Elem. Coll. Sec. Adv.

Siblings ____ Relationship of guardian to child ____________________

Home Situation: One parent ( ) Mother remarried ( ) Restructured – Stepfather/mother ( ) Father Remarried ( )
Mother Remarried ( ) Both Parents ( )

Parental Rights (in case of separation or divorce) __________________________________ (Attach Copy of Court Order)

Language (other than English) spoken at home ____

REASONS FOR ENROLLMENT

Please number in order of priority:

1. Formation in Faith/Values ____
2. Good Discipline ____
3. Academic Excellence ____
4. Nurturing Atmosphere ____
5. Proximity to Home ____
6. Recommendation ____
7. Parent(s) Attended ____
8. Other ____

Has your child attended Pre-School? YES ( ) NO ( ) If yes, where __________________________________ Years? ______

Has your child ever been screened or evaluated for social, emotional, behavioral, academic/educational concerns? YES ( ) NO ( )

If yes, when _____________________________________ for ____.

Do you intend to enroll your child at St. Joan of Arc School for 1st grade? YES ( ) NO ( )

Providing this information will enable us to better plan for your child's education. Confidentiality will be respected.

REGISTRATION AFFIDAVIT

COMMONWEALTH OF PENNSYLVANIA :
: ss:
COUNTY OF DAUPHIN :

As mandated by Section 1304-A of the Public School Code, I

______________________________, the (parent/guardian/other responsible person)
(Circle one)

of ______________________________ residing at ___________________________
(Name of Student)

______________________________, hereby swear or affirm that the student

_____ has
(Check One)
_____ has not

been previously suspended or expelled from any public or private school of the Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property.

I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. 4904 relating to unsworn falsification to authorities.

“The Parents and/or Guardians of the applicant student hereby agree that they and their applicant student will abide by each of the policies and procedures that may be adopted from time to time by the Diocese of Harrisburg and by St. Joan of Arc School, including but not limited to those set forth or referred to in St. Joan of Arc’s School student handbook.”

____
Signature Date

AGREEMENT

The undersigned agrees, intending to be legally bound, in consideration of the Student’s enrollment at St. Joan of Arc School, to be responsible to pay tuition as is determined from year to year by the Board of Education; and published by the school.

The undersigned agrees that they and their child will abide by the policies and procedures that may be adopted from time to time by the diocese or the school, particularly those set forth in the school’s handbook.

Parents and/or Guardian __________________________________ Date ___________

ST. JOAN OF ARC SCHOOL

In order to comply with state guidelines, we are required to have a Home Language Survey on file for each student.

Student Name____ Date________________

School____ Grade_______________

1. What language(s) did the student first learn to speak?

   ____

2. What language(s) does the student speak at home?

   ____

3. What language(s) does the student speak most often?

   ____

PLACE IN PERMANENT RECORD FILE

(If any answer contains a language other than English, please send a copy to the designated school staff member.)

Form A

Language Minority Student Educational Profile **ST. JOAN OF ARC SCHOOL**

___________________________________ ____________________ Gender ____M ____F

(Student Name) (Date of Birth)

U.S. Entry Date_____________________ First Language_____________________________

Date Entered District________________

English speaking contact name and phone number

____

EDUCATIONAL BACKGROUND

Did the student attend school in his/her country? Yes____ No____

If yes, how many years?_______

Did student study English before coming to the U.S. ? Yes____ No____

If yes, how many years? _______

In English, can the student:

Read Yes____ No____

Write Yes____ No____

Speak Yes____ No____

In the first language, can the student:

Read Yes____ No____

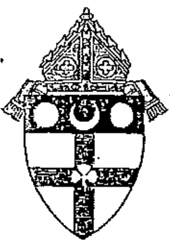
Write Yes____ No____

ESOL or Bilingual Program in the U.S.? Yes____ No____

If yes, where?____

Has the student repeated any grade? Yes____ No____

Circle all that apply: K 1 2 3 4 5 6 7 8 9 10 11 12



DIOCESE OF HARRISBURG – SECRETARIAT FOR EDUCATION
4800 Union Deposit Road • Harrisburg • Pennsylvania 17111-3710
(717) 657-4804 • FAX (717) 657-3790 • www.hbgdiocese.org

CATHOLIC SCHOOL PARENTS MEMORANDUM OF UNDERSTANDING

As a parent/guardian of a student in a Catholic School I understand and affirm the following:

1. The primary purpose of a Catholic school education is to form students in the values of Jesus Christ and the teaching of the Catholic Church.
2. Catholic schools are distinctive religious education institutions operated as programs of the Catholic Church; they are not private schools but are administered and supported by the sponsoring parish(es), and the diocese.
3. Attending a Catholic school is a privilege, not a right.
4. While academic excellence and involvement in extracurricular activity (i.e., sports, clubs, etc.) are important, fidelity to the Catholic identity of the school is the fundamental priority.
5. The school and its administration have the responsibility to ensure that Catholic values and moral integrity permeate every facet of the school's life and activity.
6. In all questions involving faith, morals, faith teaching, and Church law, the final determination rests with the diocesan bishop.

As a parent/guardian desiring to enroll my child in a Catholic school, I accept this memorandum of understanding. I pledge support for the Catholic identity and mission of this school and by enrolling my child I commit myself to uphold all the principles and policies that govern a Catholic school.

Father: ______________________ Mother: ______________________
Printed Printed

______________________ ______________________
Signature Signature

(Guardian): ______________________ ______________________
Printed Signature

Student's Name______________________

School: ______________________ Date: ______________

CERTIFICATE OF INDIVIDUAL REQUEST
FOR LOAN OF INSTRUCTIONAL MATERIALS

TO: SECRETARY OF EDUCATION
DEPARTMENT OF EDUCATION
BOX 911
HARRISBURG, PENNSYLVANIA 17126

I hereby request the loan of instructional materials in accordance

with Act 90 of 1975, for my child(ren) attending St. Joan of Arc

in Hershey, Dauphin
Borough, City, Town County

Signed ______________________________
Parent, Guardian

Date ________________________________

N.B. Act 90 applies to Pennsylvania residents attending schools in Pennsylvania only.

TO: SECRETARY OF EDUCATION
COMMONWEALTH OF PENNSYLVANIA

CERTIFICATE OF INDIVIDUAL REQUEST
FOR LOAN OF TEXTBOOKS

I hereby request the loan of textbooks and instructional materials in accordance with Pennsylvania Act 195-1972 for my child(ren) attending

SAINT JOAN OF ARC SCHOOL

Date __________ Signed ____
(Parent/Guardian)

N.B. This law is applicable to PA residents attending schools in PA only.

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before student's exam. Take completed form to appointment.

Student's name ______________________________ Today's date__________________

Date of birth ____________________ Age at time of exam___________ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

____

____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student…*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other______________________		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student…*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:__________		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student…*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student…*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? ______ Date of last period: ___________		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: ______________________ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student…*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other______________________		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other__________		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student______________________________ Date____________

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

 STUDENT NAME:

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐				
Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE** NORMAL	*ABNORMAL	DEFER	***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ **No** ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ **School** ☐ **Date of exam**______________**20**______

Print name of examiner ____

Print examiner's office address____ **Phone**____________________

Signature of examiner____ **MD** ☐ **DO** ☐ **PAC** ☐ **CRNP** ☐

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:___________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME:

Grade:	School:

PLEASE COMPLETE AND RETURN PROMPTLY
The health information requested here will aid the school personnel in providing for your child's health, safety, and educational needs.

Student Name	Sex	Date of Birth
Address	Phone Number	
Father's Name	Mother's Name	

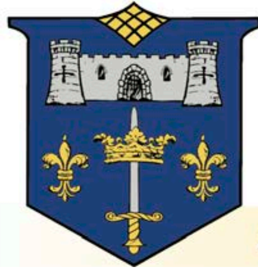
Family Physician	Family Dentist
Address	Address
Phone Number	Phone Number
Date Last Seen	Date Last Seen

List any health emergency that might occur at school (Bee sting allergy, asthma, seizure).
Please include symptoms that are warning signals.
List any special health problems or needs that the school should know about.

Does your child have any of the following health concerns? Provide a brief explanation to all YES answers

	No	Yes	Explanation
Serious or recurring illness	☐	☐	
Serious accident, injury, broken bones	☐	☐	
Operations or hospitalizations	☐	☐	
Allergies or adverse reactions	☐	☐	
Special diet or food allergies	☐	☐	

Parent/Guardian's Signature ______________________ Date ______________



St. Joan of Arc School

A National Blue Ribbon School of *Excellence*

TO: Parents/Guardians of Kindergarten and/or NEW Students

FROM: Amy Creasy RN, CSN

The Pennsylvania State Department of Health (28 PA Code Ch.23) requires that all new entrants to Kindergarten receive the following examinations and immunizations:

1. Physical examination
2. Dental examination
3. Immunizations as listed below
    a. 4 doses of DPT with a possible 5th dose if the 4th dose was given before the 4th birthday
    b. 4 doses of polio vaccine with a possible 5th dose if the 4th dose was given before the 4th birthday
    c. 2 doses of MMR
    d. Hepatitis B series of 3 doses
    e. 2 doses of Varicella vaccine or written proof of chicken pox disease
    f. 1 dose of Tdap (1 dose prior to entering 7th grade)
    g. 2 doses of MCV (1st dose prior to entering 7th grade & the 2nd dose prior to 12th grade)

In accordance with the above regulations, your child WILL NOT be admitted to school until the certificate of immunization or exemption is completed by your physician or other health care provider. Any incomplete immunizations must be accompanied by a written plan of completion.

In order for your son/daughter to attend class on the first day of school, we ask that you submit the above immunizations/exams records to the school nurse no later than **August 1st.**

The examinations may be completed no earlier than one year prior to the first day of Kindergarten/school.

Please call the school office with any questions or concerns. Thank you for your cooperation in this matter.

Updated Oct 2017

Tuition Payment Instructions

Dear Parents,

After completing the registration forms please set up a tuition account through FACTS, our tuition collection company.

1. To sign up it is super easy. Here is the link. https://online.factsmgt.com/signin/3N8WK

   4 easy steps

   a. Create an account (your name and address).
   b. Add student's name and grade.
   c. Choose payment options (automatic withdraw, credit card, or invoice).
   d. Add financial info.

2. Payment Dates: You may choose either the 5th, 10th, or 15th of each month as your payment date. Automatic payments can be made from a checking or savings account or from a variety of credit cards.

3. Payments made in full by July 15 will receive a 2% discount and no additional fee if paid by check. (If you choose to pay by credit card a 2.9% fee will be added). If paying in 2 lump sums July and January the fee is $20. If you choose the traditional 11 monthly payment plan the fee is $40 per calendar year.

4. Scrip scholarship credits will still work the same. Credits will be forwarded to Facts and your future payment will be adjusted accordingly to your credit received.

   If you have any further questions, please feel free to contact Deb Rizzotto at drizzotto@stjoanhershey.org