

St. Ignatius Loyola Regional School

Faith in Every Child

2700 St. Albans Drive ♦ West Lawn, PA. 19609

- ◇ Baptismal Cert.
- ◇ Medical Forms
- ◇ Dental Forms
- ◇ Parish Verified
- ◇ Birth Certificate
- ◇ Accept
- ◇ POWERSCHOOL
- ◇ Letter Sent
- ◇ July Newsletter
- ◇ Family Label

FOR OFFICE USE

FACTS Option _____
Reg. Fee \$ _____ Technology Fee \$ _____
Check No. _____ Date _____

Registration Form

Kindergarten to 8th Grade

Student Name _____
First Middle Last Name to be used in school

Home Address _____
Street City State Zip Home Phone

Guardianship _____
Name of step parent (if applicable) Phone

Is your child adopted? Yes (please provide adoption certificate) No

Child's Age _____ Date of birth _____ Place of birth _____

Person Financially responsible for tuition; _____ (Please note: Tuition rates are based on active membership of child and parent/guardian either at St. Ignatius Loyola or St. Francis de Sales Parish)

Father's Name _____
Last First Address if different from student's Phone if different from student's

Check if deceased Father's place of birth _____

Father's Daytime Phone _____ Employer _____
City State

Father's Occupation _____ Father's Education _____

Father's Cell Phone/Pager _____ Father's E-mail Address _____

Father's Ethnicity Caucasian African-American Asian/Pacific Islander American Indian Hispanic Multi-racial

Marital Status _____ Religion _____ Parish _____

Mother's Name _____
Last First Address if different from student's Phone if different from student's

Check if deceased Mother's place of birth _____

Mother's Daytime Phone _____ Employer _____
City State

Mother's Occupation _____ Mother's Education _____

Mother's Cell Phone/Pager _____ Mother's E-mail Address _____

Mother's Ethnicity Caucasian African-American Asian/Pacific Islander American Indian Hispanic Multi-racial

Marital Status _____ Religion _____ Parish _____

Emergency Contact (other than parents) and Medical Information

Name _____ cell home work
 Last First relationship Phone

Name _____ cell home work
 Last First relationship Phone

Student Physician _____ Phone _____

Student Dentist _____ Phone _____

Allergies _____ Treatment _____
 food, drug, bee sting, other

I, the parent/guardian of _____, the parent/guardian of _____ authorize St. Ignatius Loyola Regional School, in the Wilson School District, personnel to provide first aid services to my child as stated in the standing orders prescribed by the Wilson School District physician. In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to make whatever arrangements appear necessary for the immediate care of my child.

Hospital preferred _____ (In an emergency requiring so, the nearest hospital will be used.)

I give my permission for the school nurse or her designee to administer the following medications to my child according to the school's standing medication orders:

YES	NO

- Acetaminophen (fever, headache, pain) (Provided by Parent)
- Benadryl (allergic reactions) - Please note, the nurses avoid using Benadryl for mild seasonal allergies since it may make students sleepy, however it is possible it may be needed for more serious allergic reactions such as hives, insect sting and food reactions, etc.
- Mylanta or Maalox (upset stomach)
- Ibuprofen (cramps, muscular/skeletal pain, severe headaches) (Provided by Parent) 7th & 8th Grades only

Parent or legal guardian signature

Date

Note: The following first aid supplies (or their generic substitutes) are also used to treat students in the health room: EpiPen Kit- for severe allergic reactions, Albuterol- for severe breathing difficulty (Parents should provide students' own EpiPen or asthma meds when known problem), Bacitracin ointment, sterile eyewash (eye irritation or foreign body in eye), PhisoDerm cleanser, alcohol, calamine lotion, sterile saline solution (contact lenses), vinyl and latex gloves. If your student has an allergy to any of these products, please list the allergy on the "Food and drug allergy" line below.

LIST ALL CURRENT MEDICATIONS:

Medication/Dosage/Time Given:	Taken For:

STUDENT'S MEDICAL HISTORY: Please check yes or no for each

	Yes	No	Explain further where needed
ADD/ADHD			
Asthma			
Diabetes			
Bee Sting Allergy			
Glasses/Contacts			For distance, near, or constant wear:
Hearing Difficulties			
Seizure Disorders			
History of major illnesses or surgeries			List:
Condition limiting physical education			Describe:
Other chronic or recurrent condition			List:

If you have answered **yes** to any of the above health conditions, please write the plan of action you want the school nurse to take when the health condition arises. The school nurse may need to contact you to have a medical plan of action completed by your child's physician.

Child's Gender Female Male Entering Grade _____ Number of Brothers _____ Number of Sisters _____
Check one

*If entering Kindergarten, please choose ALL DAY Half-Day (AM)

Public School District _____ *Busing needed AM Busing needed PM

*Please check w/your school district to see if they provide AM busing

After School Care needed (Hours 2:30 PM – 6:00 PM for grades K-8):

Yes (please complete Extended Care registration packet) No

If attended another school previously, name/address of school

Date last attended _____

Reason for transfer _____

Has child had previous experience, i.e. nursery school, day care, camp or other _____

Is another language spoken at home? Yes, _____ No

Does your child have speech difficulty? _____ Does your child have hearing difficulty? _____

Does your child have any particular fears that we should know about? _____

Does your child exhibit any particular habits (thumb sucking, nail biting, etc)? _____

Has your child received any special services (counseling, etc)? Yes, because _____ No

What are your child's strengths and interests? _____

Other comments

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Diocese of Allentown HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for identification.

School District: _____

Name of Child: _____ **Date:** _____

Address: _____ **Grade:** _____

School: _____ **Birthplace:** _____

1. What is/was the student's first language? _____

2. Does the student speak a language(s) other than English? Yes No

If yes, specify the language(s): _____

3. What language(s) are spoken in your home? _____

4. Has the student attended any United States school in any 3 years during his/her lifetime? Yes No

If yes, complete the following:

Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person completing this form (if other than parent/guardian): _____

Parent/Guardian signature: _____

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.