St. Gregory
CATHOLIC SCHOOL

115 Pine Street
Zelienople, PA 16063
phone 724-452-9731
fax 724-452-4064
email schooloffice@stgregzelie.org
www.stgregzelie.org

Dear Parent/Guardian,

Thank you for making Saint Gregory's your school of choice. We look forward to working with you and your child for many years to come. Please read the information below and sign and leave this paper with your registration papers.

Registration Acceptance Information for Saint Gregory School

The following items all play a part in acceptance to Saint Gregory School:

1. siblings of those already enrolled at Saint Gregory School are accepted first
2. members of St. Gregory, St. Ferdinand & Holy Redeemer Parishes are accepted next
3. all others are accepted next
4. payment of the registration fee
5. registration in the FACTS tuition program by **June 1**
6. receipt of the first tuition payment by your selected payment date in **August**
7. must agree to pay your full tuition balance by your selected payment date in **May**
8. completion and return of all necessary paper work
9. commitment to keep your child at Saint Gregory School
10. willingness to be an active member of the Parent/Teacher Guild (K-8)
11. acknowledgment of the Family Share Program (K-8)
12. probation period of 90 days for any student transferring to St. Gregory School within the year.

The school will notify all parents of their child's acceptance or placement on the waiting list by the end of February at the latest. Failure to have all necessary information in without prior notification to the school will result in your child being placed at the bottom of the waiting list. If your child is placed on a waiting list and there are openings at a later date, you will be notified immediately of the opening. It is always our hope that we are able to accommodate every child. If you understand and are willing to abide by all of the above, please sign below and return with your registration form and information.

Signature	Please Print Name	Today's Date

Registration Application Today's Date: _____

There is a onetime, non-refundable, registration fee of $100.00 per family.
Students entering Kindergarten must be 5 years of age on or before the 1st of September.
Students entering 4 year preschool must be 4 years of age on or before the 1st of September.
Students entering 3 year preschool must be 3 years of age on or before the 1st of September.

St. Gregory CATHOLIC SCHOOL

All registrations are subject to approval by the pastor and principal. All registration forms must be accompanied by the appropriate paper work.

STUDENT DATA

Name: _____ Gender: ___ ___
Last First Middle M F

What name does your child prefer to be called: _____ Entering Grade: (for preschool mark P3 or P4: _____

Address: _____ Development (if applicable): _____

City, State, Zip: _____ Primary Phone: _____

Primary E-mail (Please print very clearly): _____

Date of Birth: _____ Place of Birth: _____ Age as of September 1: _____

Please mark the public school district in which you reside and which elementary building your child would attend if not enrolled at St. Gregory:

District: _____ Building: _____

Student's Religion: _____ If Catholic, list parish: _____

Ethnicity: ☐ Caucasian ☐ African-American ☐ American Indian-Native Alaska ☐ Asian ☐ Hawaii-Pacific Island ☐ Hispanic ☐ Multi Racial

Current School (if any): _____ Address of Current School: _____

TRANSPORTATION: Child will be a: ☐ Car Rider ☐ Bus Rider ☐ Walker

FAMILY DATA

Father (Last, First): _____
Address (if different): _____
Employer: _____
Occupation: _____
Cell Number: _____
Work Number: _____
E-Mail (optional): _____
Religion: _____
Parish where registered: _____

Mother (Last, First / Maiden): _____
Address (if different): _____
Employer: _____
Occupation: _____
Cell Number: _____
Work Number: _____
E-Mail (optional): _____
Religion: _____
Parish where registered: _____

FOR OFFICE USE ONLY:

☐ Acceptance Information ☐ Registration Form ☐ Registration Fee #_____
☐ Immunization Records ☐ Birth Certificate ☐ Baptism Certificate (unless baptized at St. Gregory)
☐ Emergency Information Form ☐ Health History Form ☐ Pastor Verification
☐ Academic Records ☐ Discipline Records ☐ Psychological Report (if applicable)

FAMILY DATA CONTINUED

Student resides with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Joint Custody ☐ Other

Parents marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Parent

Student's legal guardian (if other than parent): _____ Relationship to student: _____

Custody: A legal document stating guardianship must be provided in cases of divorce with sole and/or shared custody.

Please list all siblings: (even those not attending St. Gregory)

Name:	Gender:	Date of Birth:

SACRAMENTAL INFORMATION:

	Date:	Church:	Address of Church:
Baptism			
First Reconciliation			
First Holy Communion			
Confirmation			

EMERGENCY CONTACT INFORMATION: (in case a parent cannot be reached)

Emergency Contact A:

Name: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Emergency Contact B:

Name: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

PICK UP LIST

Please list any person who is permitted to pick your child/ren up from school.

Is there anything else we should be aware of?

_____

_____

_____

In order to provide the best education possible for your child, please complete the following:

Has your child ever:

1. Had a psychological evaluation? ☐ Yes ☐ No

2. Been diagnosed with any of the following? ☐ Yes ☐ No If yes, please check all that apply.
   ☐ LD (Learning Disability) ☐ ADD (Attention Deficit Disorder) ☐ ADHD (Attention Deficit Hyperactive Disorder)
   ☐ ASD (Autism Spectrum Disorder) ☐ ODD (Oppositional Defiant Disorder) ☐ Other
   Does your child take medication associated with this diagnosis? ☐ Yes ☐ No
   If yes, please specify: _____

3. Received any of the following services? ☐ Yes ☐ No If yes, please check all that apply.
   ☐ Counseling ☐ Emotional Support ☐ Gifted Support ☐ Remedial Math ☐ Remedial Reading
   ☐ Speech / Language ☐ Project Dart ☐ Learning Support ☐ Other

4. Had or been recommended for an IEP? ☐ Yes ☐ No If yes, what is the disability? _____
   Please submit a copy of the IEP.

5. Been diagnosed with a medical condition that the school should be aware of? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

6. Repeated a grade. ☐ Yes ☐ No If yes, which grade? _____
   Why? _____

7. Received a suspension from school? ☐ Yes ☐ No If yes, please explain. _____
   _____

8. Been asked to leave a school? ☐ Yes ☐ No If yes, please explain. _____
   _____

9. Been expelled from school? ☐ Yes ☐ No If yes, please explain. _____
   _____

Parent/Guardian Signature: _____ Date: _____

Please return this Application Packet with a non-refundable registration fee of $100 made payable to St. Gregory School.

In order for a student to be accepted and registration finalized, all documentation as noted on the bottom of the first page must be submitted.

New students are accepted on a probationary basis. New students and their families should be cognizant of, and willing to comply with, all school expectations. If problems arise during the probationary period, which have not been resolved, the student will be required to transfer out.

STUDENT EMERGENCY INFORMATION FORM

Please complete this form for each of your children so that the school will be better prepared to deal with the special health/medical needs of your child/ren.

Child's Name: _____ Date of Birth: _____

1. Apart from vitamins, is your child taking any medicine, tablets, drugs, allergy injections?

   Yes _____ No _____ If yes, what? _____

   Reason for medication: _____

2. Is your child going to a hospital, clinic or doctor at the present time?

   Yes _____ No _____ If yes, who/where? _____

   Why: _____

3. Does your child have any allergy to anything such as foods, plants, insects, medicine?

   Yes _____ No _____ If yes, what? _____ **Is it life threatening?** _____

   Reaction: _____

4. Has your child had any convulsions or seizures (sometimes called "fits" in the past year?

   Yes _____ No _____ If yes, how many? _____ Treatment: _____

5. Does your child need a special diet or have any food problems?

   Yes _____ No _____ If yes, please explain? _____

   _____

6. List any operations or serious illness that your child has had. Please include dates or approximate age: _____

   _____

7. Does your child have any special needs or problems about which the school should be aware of other than those already mentioned?

   Yes _____ No _____ If yes, please explain? _____

   _____

Insurance Information

Child's Physician	
Physician's Phone:	
Insurance Company:	
Insurance Company Phone:	
Policy Number:	
Group Number:	
Identification Number:	
Policy Holder:	
Employer:	

IN CASE OF AN EMERGENCY REQUIRING IMMEDIATE MEDICAL TREATMENT, I give my permission to transport this student, if necessary, to the nearest Hospital. If an ambulance is necessary, the closest service will be called.

I assume the responsibility for payment. _____ _____
Signature of Parent/Guardian Date

I consent to the following emergency procedure by the Emergency Room personnel, when necessary:

Blood withdrawal and urine test. _____ _____
Signature of Parent/Guardian Date

I consent to the following medication being distributed to my child by the school personnel as needed. I understand that for medication that must be taken on a long-term basis (both prescription and over-the- counter) I must get a form signed by my child's doctor. This form is available in the school office.

Please sign below if you give consent for the school to provide the following to your child/ren:

Acetaminophen (Tylenol), Ibuprofen (Motrin/Advil), Tums, Neosporin, Benedryl Spray, Cortizone Cream, Cough Drops, Forehead or Ear Thermometer

Yes, I consent: _____
Signature of Parent/Guardian

SENECA VALLEY SCHOOL DISTRICT
HEALTH HISTORY

To Parent/Guardian: The information requested on this form will be of help to the school personnel in determining the health status for your child and in assisting him to receive maximum benefits from his educational opportunity.

Student's Full Name _____ Birth Date _____ Male _____ Female _____

Complete Address _____ Telephone No. _____
Home Cell

Name of Father or Guardian _____

Mother's Full Name (include maiden) _____

Name of Family Physician _____ Family Dentist _____

Has your child had a medical examination in the past year? _____ Dental Examination _____

A. Pre-Natal Health History — Put a Circle Around the Answer

1. Did the mother have any illness during the pregnancy? No Yes
   If Yes, explain _____
2. Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? No Yes
   If Yes, explain _____
3. Did the baby come on time? No Yes
   If No, explain _____

B. Developmental History

1. What was the baby's birth weight? _____
2. Did the baby have any trouble while in the hospital? No Yes
3. Did the baby have any special problems in the first six months? No Yes
4. At what age did the child sit alone without support? _____
5. At what age did the child walk alone without support? _____
6. At what age did the child begin to say two or three words together? _____
7. Can the child use the toilet without help? No Yes
8. If the child has stopped wetting the bed, at what age did he/she stop? _____

C. Family Health History

1. Indicate on the line which family member (parent, grandparent, aunts, uncles, brothers, sisters, etc.) had any of the following diseases:

Allergy	_____	Asthma	_____
Cancer	_____	Diabetes	_____
Drug Or Alcohol Addiction	_____	Heart Disease	_____
Nervous Breakdown	_____	Seizures	_____
Tuberculosis	_____	Lead Poisoning	_____
Sickle Cell	_____	Vision	_____
Hearing/Learning Problems	_____	Anemia	_____

Other inherited or family diseases: _____

2. Family Members

(note any special relationship such as step-parent, adopted, foster-child, etc.)

Relationship	Age	Name	State of Health	Occupation or School	Grade Reached in School
Mother					
Father					
Brothers					
Sisters					

3. Have any members of the family died? No Yes
(Not Miscarriages)
If Yes, explain _____

4, Including the child how many people live in the same house? _____

5. Are there any family problems such as problems with housing, employment, food, etc. No Yes

D. Health History

1. If the child has had any of the following, please indicate the date.

Bronchitis	_____	Chicken Pox	_____
Diabetes	_____	German Measles (Rubella)	_____
Jaundice	_____	Malignancy	_____
Measles (Rubeola)	_____	Mumps	_____
Scarlet Fever	_____	Rheumatic Fever	_____
Tuberculosis	_____	Seizure Disorder	_____
		Whooping cough	_____

Fractures (Please list bone and date):

_____
_____
_____

Surgery (Please give dates):

_____
_____
_____

Please list any serious accidents:

_____
_____
_____

2. Is you child subject to any of the following?
(Please circle and explain briefly)

Allergies(specify): _____
Asthma: _____
Blood Disorder: _____
Bone, joint, or muscle problems: _____
Ear problems: _____
Fainting: _____
Frequent colds: _____
Frequent sore throats: _____
Headaches: _____
Heart problems: _____
Intestinal problems: _____
Kidney or urinary problems: _____
Liver problems: _____
Nosebleeds: _____
Seizures: _____
Sinus infections: _____
Skin problems: _____
Speech problems: _____
Stomach problems: _____

List any known serious sensitivity or conditions requiring IMMEDIATE MEDICAL ATTENTION.

_____
_____
_____

Is your child now under care for any chronic condition?

_____

If so, give name of physician if different from family physician.

_____

E. Put a circle around any of the following things which worry you about the child?

1. Bedwetting
2. Wetting During the Day
3. Thumbsucking
4. Stammering or Stuttering
5. High Strung or Easily Upset
6. Too Restless
7. Shy
8. Sad or Sulky
9. Feelings Easily Hurt
10. Wanting Too Much Attention
11. Wanting Too Much Comfort or Support From Parent
12, Day Dreams
13. Nightmares
14. Temper Tantrums
15. Contrary or Stubborn
16. Disobedient
17. Lying
18. Selfish in Sharing
19. Jealous of Brothers or Sisters
20. Fighting with Other Children
21. Purposely Destroys Things
22. Feeding
23. Bowels
24. Any other problems not mentioned?

What? _____

_____

_____

Health History obtained from:

_____

Parent/Guardian

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 _____.
Date

Result of Diagnostic Studies: _____.
Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐No ☐ Yes _____
Date

Significant Medical Conditions

	Yes	No	If Yes, Explain
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

• 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 Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____ _____
Signature of Examiner **Print** Name of Examiner

_____ _____
Address Telephone Number

H514.027

COMMONWEALTH OF
PENNSYLVANIA DEPARTMENT
OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL_____ DATE_____ 20 ____

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip

REPORT OF EXAMINATION

		TOOTH CHART																
		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	UPPER
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	LOWER
	UPPER																	UPPER
	LOWER																	LOWER

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address

2019-2020

PASTOR VERIFICATION FORM

For Attendance at a Catholic Elementary School in the Diocese of Pittsburgh

Family Name: _____

	Student Name	**2019-20 School**	**2019-20 Grade**	**Principal Verification** (Please Initial)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Y	N	
__	__	The child(ren) listed above is/are baptized.
__	__	The family is a registered participating member of the parish.

_____ _____ _____

Pastor or Administrator Signature | Date | Comments

_____ _____

Parish Name | Location #

***Note to Parents*: If you are a member of a parish without a school or your school has no room or an incomplete K-8 program, you must have your pastor sign this form and present it to the school principal by May 31st.**

***Note to Principal*: Please initial the last column for each child who attends your school in the current year and remit a copy of all forms (only families from Catholic parishes without schools or families from parishes with schools who have no room or an incomplete K-8 program) to the Department for Catholic Schools by September 29, 2019.**

***Note to Pastor*: Signing this form in no way affects your parish assessment for the Diocesan Elementary School Grant Program. If you are a pastor with a school and are signing for parents to attend another school, please indicate the circumstances under "comments" (i.e. no room, no 7^{th} or 8^{th} grade, etc.).**