CHECKLIST FOR KINDERGARTEN

"Cannot Attend First Day of School without all requirements completed and in Office..."

Student's Name:_____

- ☐ **Student School Registration Form**
- ☐ **Health History Form**
- ☐ **Baptism Certificate (**If Baptized at St. Michael's Church and on record at Parish Office, one is not needed)
- ☐ **Immunization Record**
- ☐ **Food Allergy Action Plan**
- ☐ **Field Trip Consent Form**
- ☐ **Photography Consent Form/release**
- ☐ **Physical examination**
  (all Kindergarten and out-of-state students transferring schools)
- ☐ **Dental form (Kindergarten Only)**
- ☐ **Vision Evaluation (Kindergarten Only)**
- ☐ **Certified Copy of Birth Certificate**
- ☐ **Parent/Student Handbook Sign-Off Sheet**
- ☐ **Speech/Language Development Questionnaire**
- ☐ **Home Language Survey**
- ☐ **Permission Slip**
- ☐ **Technology Use Policy Form**

Enrollment Application

St. Michael's Catholic School
1315 1st Ave
South Sioux City, NE 68776
4024941526

Website: http://stmichaels.schoolinsites.com/
Lora Crowe, Principal loracrowe@smcsssc.com
Daniela Padilla, Office Manager daniela@smcsssc.com

St. Michael's Catholic School
Permanent Student Record

Date: _____

Student Name: _____ Grade Applied For:_____
(First) (Middle) (Last)

Place of Birth: _____ Date of Birth: _____ Gender: _____

1st Language: _____ Religion: _____ Parish: _____-_____

Ethnicity: _____ Hispanic/Latino _____ Non-Hispanic/Latino

Race: PLEASE CHECK ALL THAT APPLY _____American Indian/Alaska Native _____ Asian

_____ African American _____White _____ Native Hawaiian/Pacific Islander

Home School District: _____

IEP/Special Assistance Plan/Medical Needs/Other? _____

Parents/Guardians Information:

Name: _____ Relationship: _____Church Affiliation: _____

Address: _____ City: _____State: _____ Zip Code:_____

Occupation: _____ Company Name:_____

Cell Phone: _____ Cell Phone Carrier: _____

Home Phone: _____ Work Phone: _____

Primary E-mail: _____

Name: _____ Relationship: _____Church Affiliation: _____

Address: _____ City: _____State: _____ Zip Code:_____

Occupation: _____ Company Name:_____

Cell Phone: _____ Cell Phone Carrier: _____

Home Phone: _____ Work Phone: _____

Primary E-mail: _____

Home Information:

Parents married [ ] One parent [ ] Parents Separated or Divorced [ ]

Restructured-Stepfather/Stepmother [ ] Father remarried [ ] Mother remarried [ ]

Child resides with: _____

Siblings: _____ _____ _____ _____

Name Age Name Age

_____ _____ _____ _____

Name Age Name Age

_____ _____ _____ _____

Name Age Name Age

_____ _____ _____ _____

Name Age Name Age

Parental Rights (in case of separation or divorce): _____ (Provide copy of court order)

Language (other than English) spoken at home: _____

Emergency Contacts:

Name: _____ Relationship to Child: _____

Address: _____ Phone Number: _____

City, State, Zip: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone Number: _____

City, State, Zip: _____

Religious Background:

Registered Parish: _____ Location: _____

Baptism: _____ _____ _____

Church Name City & State Religion

First Penance: _____ _____ _____

Church Name City & State Religion

First Communion: _____ _____ _____

Church Name City & State Religion

Confirmation: _____ _____ _____

Church Name City & State Religion

Medical Information:

Doctor: _____ Doctor's Phone Number: _____

Hospital Preferred: _____ Allergies/medical condition: _____

Medication: _____ Dosage: _____

Dentist: _____ Dentist's Phone Number: _____

Academic Record **(Pre-K or Kindergarten applicants include day care experiences):**

School Attended: _____ Date Enrolled: _____Date Withdrawn: _____

Reason for leaving: _____

School Attended: _____ Date Enrolled: _____Date Withdrawn: _____

Reason for leaving: _____

School Attended: _____ Date Enrolled: _____Date Withdrawn: _____

Reason for leaving: _____

Has your child ever been suspended, expelled, dismissed, or not allowed to re-enroll in a school?
[ ] No Yes [ ] If yes please provide the name of the school and the reasons on a separate sheet of paper.

Has your student ever been tested or evaluated for any disability [i.e., earning disabilities, ADD/ADHD, emotional disabilities, etc.], English as a Second Language, or medical condition? [ ] No [ ] Yes

If yes, please describe on a separate sheet of paper any disability or medical condition that may affect your child's ability to fully participate in the academic program provided at St. Michaels Catholic School. If you are requesting an adjustment or accommodation to the curriculum, please describe your request.
Information about disabilities is requested for the sole purpose of determining whether the school can provide the applicant with an appropriate education or reasonable accommodation and will not be considered in determining whether he/she is otherwise qualified for admission.

Parent Questionnaire:

How did you learn about St. Michaels Catholic School? _____

What are the first three words that come to mind when you think of your child?

_____

Which activities or hobbies does your child enjoy most?

_____

Describe times when your child is happiest.

_____

How do you feel that your child learns best?

_____

What led you to consider St. Michaels Catholic School for your child?

_____

_____

_____

_____

What are your goals for your child at St. Michaels Catholic School?

_____

_____

_____

_____

Preschool/Kindergarten/Transitional Kindergarten

SPEECH/LANGUAGE DEVELOPMENT QUESTIONAIRE

Child's Name:_____Child's Date of Birth_____
Parent:_____Address:_____
Phone:_____Date:_____

Your child may be screened at teacher or parent request.

Yes No 1. Do family members *frequently* have difficulty understanding your child's speech?

Yes No 2. Does your child ever become frustrated because of his/her speech or language?

Yes No 3. When your child talks, are his/her sentences *always less* than five words in length?

Yes No 4. Does your child have difficulty understanding directions?

5. Does your child have difficulty with any of the following:

Yes No A. Carrying on a conversation with you by telling you what he/she is doing?

Yes No B. Asking questions such as why, when, and how?

Yes No 6. Are you concerned about your child's hearing?

Yes No 7. Do you feel your child stutters?

Yes No 8. Do you have any questions about your child's speech and language development?

HOME LANGUAGE SURVEY

School:_____ Grade:_____ Date:_____

Student Name: _____ Birth Date:_____ Gender: __Male __Female

Parent/Guardian Name:_____

Address:_____

Home telephone;_____ Work telephone:_____

What language did your child fist lean to speak?_____

What language is spoken most often by your child?_____

What language does your child most frequently use at home?_____

_____ _____

Parent or Guardian's Signature Date

ENCUESTA DE IDIOMA DOMESTICO

Escuela:_____ Grado:_____ Fecha:_____

Nombre del estudiante:_____ Fecha de nacimiento:_____ Sexo: __Masculino __Femenino

Nombre del padre o Tutor:_____

Direccion:_____

Numero de telefono del hogar:_____ Numero de telefono del trabajo:_____

Que idioma aprendio su hijo cuando empezo a hablar?:_____

Que idioma utiliza su hijo con mas frecuencia?:_____

Que idioma utiliza su hijo con mas frecuencia en el hogar?:_____

STUDENT PICK UP PERMISSION SLIP

I grant permission to the following people listed below to pick up my child/ren from St. Michael's Catholic School.

People with permission to pick up after school:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Child/ren to be picked up:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

I give permission to St. Michael's Catholic School to have my child/ren walk home from school.

Parent Signature: _____ Date:_____

Child/ren Names:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

PARENT/GUARDIAN FIELD WALKING FILED TRIP CONSENT FORM AND LIABILITY WAIVER

I, _____ (parent name) grant permission for my child/ren, _____ to walk to event activities offered by St. Michael's Catholic School. These events will be under the direction of the St. Michael's faculty/staff/parents.

I agree on behalf of myself, my child, our heirs, successors, and assigns, directors, employees, and agents, and the Arch Diocese of Omaha, its employees and agents, chaperones or representatives associated with the even from any claim arising from or in connection with my child participating/attending the event or in connection with any illness or injury/death or cost of medical treatment in connection therewith. I agree to compensate the parish/school, Arch Diocese of Omaha, its employees and agents, chaperones or representatives associated with the even for reasonable attorney fees and expenses which may occur in any action brought against them, unless such claim arises from the negligence of the parish/school/diocese.

Parent signature: _____ Date: _____

PHOTOGRAPHY CONSENT FORM/RELEASE

I, (print name) _____, parent or official guardian of (child/ren's name) _____, hereby grant permission to St. Michael's Catholic School to take and use photographs and/or digital images of my child for use in news releases and/or educational materials. This may be in the form of printed publications or material, electronic publications, or WEB sites. I agree that my child/ren's name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me.

Date: _____
Parent Signature: _____
Address: _____
City, State, Zip: _____

******** _____ **Check here ONLY IF YOU DO NOT GIVE CONSENT to the above.**

St. Michaels Catholic School Student Health Form

Student Name: (First) (Middle) (Last)

Gender Birth Date Grade

Home Address Home Phone:

City State Zip Code

Immunization Status: Submit a photocopy of your child's most up to date immunization record.

Student Medical History: Please fill in all information that pertains to your child.

Is your child currently under any medical treatment or taking any type of medication?

Medication(s): _____ Treatment: _____

Does your child have any special health problems the school should know about?

Specify: _____

Pediatrician/Family Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Date of last physical exam: _____ Date of last dental exam: _____

☐ Allergies Specify**:**_____

(examples: specific food, drug, bee/insect, environmental)

☐ Asthma ☐ Cleft palate ☐ Diabetes ☐ Epilepsy ☐ Heart disease ☐ Chicken pox

☐ Operations Specify: _____

☐ Accidents Specify: _____

☐ Serious Illness Specify: _____

☐ Physical handicap Specify: _____

☐ Family Diabetes Specify: _____

Health History

Is your child currently under the care of a doctor, hospital, or clinic right now? ☐ yes ☐ no

If yes, please explain: _____

Apart from vitamins, is your child taking any medications, tablets, or drops? ☐ yes ☐ no

If yes, please explain: _____

Has your child had any convulsions, seizures, or fits? ☐ yes ☐ no

If yes, please explain: _____

Does your child need a special diet or have any food problems? ☐ yes ☐ no

If yes, please explain: _____

Pregnancy & Birth – Please complete if your child is an applicant for Pre-K or kindergarten

Did mother have any illnesses during pregnancy: _____ ☐ yes ☐ no

Did mother have to take medication? _____ ☐ yes ☐ no

Did the baby arrive on time? ☐ yes ☐ no

Was it a long or complicated delivery? ☐ yes ☐ no

Was infant placed in an incubator? ☐ yes ☐ no

What was the birth weight? _____

How many days did the baby stay at the hospital? _____

Was the baby considered to be perfectly healthy? ☐ yes ☐ no

Illness and Accidents

Please explain each "yes' answer. Use other side if needed.

Has there been more than one ear infection each year? No or Yes _____

Have there been any hearing problems? No or Yes _____

Have there been any vision problems? No or Yes If yes when last fitted for glasses? _____

Completed by: _____

Relationship to child: _____ Date: _____

FOOD ALLERGY ACTION PLAN

IMPORTANT: Please complete attached forms if your child have any form of Allergies & return to school office as soon as possible.

ALLERGY TO:_____
Student Name:_____ D.O.B.:_____
Teacher:_____
Asthmatic: Yes*___ No___ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

-MOUTH Itching & swelling of the lips, tongue or mouth.
-THROAT Itching and / or sense of tightness in the throat, hoarseness, and hacking cough.
-SKIN Hives, itchy rash, and / or swelling about the face or extremities.
-GUT Nausea, abdominal cramps, vomiting and / or diarrhea.
-LUNG* shortness of breath, repetitive coughing and / or wheezing.
-HEART* "thread" pulse, "passing-out"

The severity of symptoms can quickly chance. *All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

1. If only symptom(s) are:_____
give_____
_____
Then call:
2. Mother_____ Father_____ or emergency contacts.
3. Dr. _____ at_____.
If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION MAJOR REACTION

1. If ingestion is suspected and / or symptom (s) are:_____
give_____
IMMEDIATELY!
Then call
2.Resucue Squad (ask for advanced life support)
3.Mother_____ Father_____ or emergency contacts.
4.Dr. _____ at
_____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's signature_____ Date_____
Doctor's Signature_____ Date_____

ATTACHMENT A: Emergency Care Plan

To be used for a child with known asthma/anaphylaxis
NAME_____ GRADE_____
AGE_____
SCHOOL_____
TEACHER_____
Parent/Guardian Name_____ Phone (H)_____
Address_____ Phone (W)_____

Parent/Guardian Name_____ Phone (H)_____

Address_____ Phone (W)_____

Emergency Contact #1_____

Phone_____

Emergency Contact #2_____

Phone_____

Physician student sees for asthma/anaphylaxis_____

Phone_____

NATURE OF ASTHMA/ANAPHYLAXIS- Describe, including triggers, signs and symptoms of allergic response and known allergens.

_____

_____

_____

_____

MANAGEMENT PLAN - Describe environmental controls and list medication prescribed. If asthma, identify zones for peak flow.

_____

_____

_____

_____

TREATMENT PLAN - Describe the steps to be taken for treatment.

_____

_____

_____

_____

_____

_____

****

RELEASE OF INFORMATION

I give the school nurse permission to contact Dr. _____ regarding this plan for my child_____.

Parent/Guardian Signature_____

Date_____

NEBRASKA
Good Life. Great Mission.
DEPT OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Physical Examination Report

Name of School (if desired)

The school board shall require evidence of (a) a physical examination by a physician, a physician assistant, or an advanced practice registered nurse…within six months prior to the entrance of a child into the beginner grade and the seventh grade or, in the case of a transfer from out of state, to any other grade of the local school; and (b) for school year 2006-07 and each school year thereafter, a visual evaluation by a physician, physician assistant, an advanced practice registered nurse, or an optometrist within six months prior to the entrance of a child into the beginner grade or, in the case of a transfer from out of state, to any other grade of the local school, which consists of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity, except that no such physical examination or visual evaluation shall be required of any child whose parent or guardian objects in writing. The cost of such physical examination and visual evaluation shall be borne by the parent or guardian of each child who is examined. Nebraska Revised Statutes 79-214 (excerpt).

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for physical examination in Nebraska schools. No specific form is required by the statute. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success.

By signing below, the parent/guardian of _____ **consents for the**
Name of Student

release of the health and medical information contained herein to be released to _____
Name of School

_____ _____ _____
Signature | Printed Name/Relationship to Student | Date

Student Name	School		Grade
Student Address	Zip	Age	Sex: ☐ M ☐ F
Physician Name			

PHYSICAL FINDINGS (use back for comments or recommendations)

Height	Weight
Blood Pressure	Pulse
Urinalysis	
Hemoglobin/Hct	

Audiometric Screening Report

	500	1000	2000	4000
RE				
LE				

Immunizations given during today's visit:
☐ DTP ☐ Td ☐ Polio ☐ MMR ☐ Hib ☐ Hep B ☐ Varicella
☐ Other (list)_____
(Please attach copy of immunization record on file.)

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
Amblyopia	☐	☐	☐
Strabismus	☐	☐	☐
Internal Eye Health	☐	☐	☐
External Eye Health	☐	☐	☐
Visual Acuity	☐	☐	☐

20 feet: Right 20/_____ Left 20/____ with/without glasses

16 inches: Right 20/____ Left 20/____ with/without glasses

Medical	Normal	Abnormal Findings
Appearance	☐	☐
Eyes/ears/nose/throat	☐	☐
Lymph Nodes	☐	☐
Heart (note murmur if present)	☐	☐
Pulses (inc. Femoral)	☐	☐
Lungs	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Musculoskeletal	☐	☐
Neck	☐	☐
Spine	☐	☐
Shoulder/arm	☐	☐
Wrist/hand	☐	☐
Elbow/forearm	☐	☐
Hip/thigh	☐	☐
Knee	☐	☐
Leg/ankle	☐	☐
Foot	☐	☐
Evidence of Scoliosis	☐ No	☐ Yes
Evidence of Hernia	☐ No	☐ Yes
Stigmata of Marfan's Syndrome	☐ No	☐ Yes

Required medication on a daily or episodic routine:

Please check classification

☐ Regular: Student may participate in the regular program of physical education, recreation, intramurals, athletics or related activities without undue risk or injury.

☐ Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special adapted program as indicated by the consulting physician. Reexamine each year.

☐ Exempt: Student has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs. These students should be reexamined for possible reclassification at the end of the exemption period.

Please check certification

☐ Certified: Student has passed the physical examination successfully and is physically able to participate in interscholastic athletics. Activities student should **not** participate in:_____

Significant findings/chronic health concerns_____
Your signature below indicates completion of physical exam and review of health history.

Date_____ Signed _____
Examining Physician (Signature Required)

Clinic/Practice Name (please print)_____Physician Phone_____

Physician Address _____
Return to School Health Office

FH-42 Rev. 11/21

Documentation of Varicella (Chickenpox)

(To be out by the parent, guardian, or medical provider of the child/student)

This document is being submitted on behalf: (Name of child/student)

_____

First Middle Last

_____

(Birthdate of child/student) mm/dd/yyyy

I. _____ verify that the above listed Child / Student

Parent/Guardian/Medical Provider

had the Varicella disease in _____ (year).

_____

(Signature of parent/guardian/medical provider)

_____

(Date)

TUITION PAYMENT AGREEMENT

Please initial the plan you choose.

One Payment Option:

_____ Payment is due by the first day of school. The one payment plan is encouraged and appreciated.

Two Payment Plan:

_____ First Payment is due August 15th with the second payment due January 15th.
A $30 per month late fee will be applied to accounts that do not have their family monthly payment in by the $15th of January.

Monthly Payment Plan:

_____ 10 payments of $330 per month per child are due by the 15th of the month starting in August and will be continued through May 15th.
***Based on $3300 tuition per year, plus #200 in student fees per student for monthly payment of $330.

It is each and every family's responsibility to make tuition payments on time. Reminder notices will not be issued when payments are due. A $30 per month late fee will be applied to accounts that do not have their family monthly payment in by the 15th of each month. If you should have difficulties making timely payment, please contact the office immediately. If no effort to make payments is made, the delinquent accounts will be brought to the School Board and Finance Committee to determine if the child/ren will be allowed to remain at St. Michael's Catholic School. Delinquent balances will be forwarded to a collection agency.

Parent Signature: _____ Date:_____