PLEASE FILL OUT BOTH SIDES COMPLETELY AND RETURN

Saint Kateri School

NEW STUDENT INFORMATION FORM

Date of Registration _____

Date of Entrance into school _____/_____/ 20_____ Grade Level entering _____

Please Print

Child's Name _____ ☐Male ☐Female

Address _____
(Street) (City/Town) (State) (Zip)

Home Land Line Phone_____ Cell Phone_____

Birth Date _____/_____/20_____ Birthplace _____

SS# ___ ___ ___ - ___ ___ ___ - ___ ___ ___ Public School District _____

Please check one: ☐ American Indian ☐ African American (non-Hispanic)

☐ Asian/ Pacific Islander ☐ Hispanic ☐ Caucasian

Last school attended_____ Grade _____

School address _____

Child lives with_____ Relationship to student_____

Parent/ Guardian (as you wish your name to appear on official communication)

Please circle one: M/M Dr Mr. Mrs. Miss Ms.

_____
(Last Name) (First Name) (Middle)

Mailing Address _____
(Street) (City) (State) (Zip)

Medical Insurance Company _____ Policy Number _____

Parish Registered at _____ Envelope # _____

Student's Religion _____

Baptism: Date_____ Church _____ Location_____

First Communion: Date_____ Church _____ Location_____

First Penance: Date_____ Church _____ Location_____

Confirmation: Date_____ Church _____ Location_____

(OVER)

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Family Information

	Father	Mother	Parent Substitute
Name First			
Last			
Middle Initial			
Address Street			
City/Town			
State/ Zip			
Email Address			
Year of Birth			
Birthplace City			
State			
Religion			
Citizenship (Country)			
Education: Last Grade			
Completed in School			
Occupation			
Place of Business			
Address			
Business Phone			
Other Languages Spoken in the Home			

Check all that apply:

Married:			
Deceased (date)			
Divorced			
Separated			
Remarried			
Single			

Other Children in the Family

Last Name	First Name	Date of Birth	School

(OVER)

WEST IRONDEQUOIT CENTRAL SCHOOL DISTRICT

Health and Development History

I. Student Information

Name_____ Sex M F Date of Birth_____

Address_____

Doctor_____ Office Number_____

Dentist_____ Office Number_____

Father's Name_____ Mother's Name_____

Child lives with: Both Parents:_____ Mother:_____ Father:_____ Other:_____

Language(s) spoken at home:_____

II. Pregnancy and Birth History: (Please complete to the best of your knowledge).

1. Did mother have any illness or complication during pregnancy or delivery? If YES, please explain:

   _____

   _____

2. Was the child's delivery date: On due date_____ Preterm____ Post Dates_____

WICSD HEALTH AND DEVELOPMENT HISTORY

Student Name _____

III.	**Development History (to be filled out by K-6 only)**	**NO**	**YES**
	Is your child shy or timid?	____	____
	Does your child play well with others	____	____
	Does your child follow directions?	____	____
	Have you noticed…if yes, explain:		
	Nail biting_____	____	____
	Thumb sucking_____	____	____
	Temper tantrums_____	____	____
	Bed wetting_____	____	____
	Did your child go to pre-school?	____	____
	If yes, where?_____		

How many days per week? _____

WICSD HEALTH AND DEVELOPMENT HISTORY

Student Name _____

IV. Health History. If you answer YES to any of the concerns below, please explain:

	NO	YES
Frequent ear aches _____	____	____
Hearing concerns_____	____	____
Ear tubes_____	____	____
Hearing aids_____	____	____
Vision concerns_____	____	____
Wears glasses_____	____	____
Wears contacts_____	____	____
Frequent sore throats _____	____	____
Bowel movement concerns_____	____	____
Urination concerns_____	____	____
Sleep difficulties_____	____	____
History of seizures_____	____	____
Dental concerns_____	____	____
History of joint or bone injuries_____	____	____
Allergies_____	____	____
Medication for allergies_____	____	____
Asthma_____	____	____
Medication/Inhaler for asthma_____	____	____
Dietary concerns (PLEASE NOTE ANY RESTRICTIONS AND INFORM TEACHERS ACCORDINGLY)	____	____

_____

_____

WICSD HEALTH AND DEVELOPMENT HISTORY

Student Name _____

V. Medical History

Has your child ever had or does he/she now have:	NO	YES
Hepatitis	____	____
Sickle Cell Anemia	____	____
Measles	____	____
Rubella	____	____
Chicken pox	____	____
Spinal Curvature	____	____
Emotional Problems	____	____
Hernia	____	____
Hemophilia	____	____
Rheumatic Fever	____	____
Scarlet Fever	____	____
Whooping Cough	____	____
Mononucleosis	____	____
Heart Disease	____	____
Kidney Disease	____	____
Joint Disease	____	____
Fainting Spells	____	____
Migraine Headaches	____	____
Head Injury	____	____
Diabetes	____	____
Pneumonia	____	____

If yes, please explain and add any additional information that is pertinent:

_____

_____

Parent Signature: _____ Date:_____

Saint Kateri School

REQUEST FOR TRANSFER OF EDUCATIONAL RECORDS

Date of Request _____

STUDENT NAME _____ ____ _____
Grade Birthdate

ADDRESS _____
City State Zip

RELEASING SCHOOL _____

ADDRESS _____
City State Zip

DISTRICT _____

_____Academic Records (grades, attendance, standardized test scores, achievement test scores. reading level, etc.)
_____Health Records (immunization card and all medical information)
_____Administrative Records (recommendations and correspondence)
_____Psychological Records (including all confidential information and testing results)
_____Special Programming (L.D., Corrective reading, Gifted and Talented, Extended Studies, Speech and Language, etc.)
_____Other

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974, and understand that I have a right to receive a copy at my own expense, if requested, and have an opportunity for a hearing to challenge the contents of the records. I understand that the information will be treated in a confidential manner and will be transmitted to a third party only through procedures in compliance with the law.

_____
Parent/Guardian Signature Date

Please send the above requested information: Saint Kateri School, 445 Kings Highway South, Rochester, NY 14617. Thank you.

Mrs. Terri Morgan, Principal