St. Peter Catholic School Upper Sandusky, OH

Enrollment Application

Please complete both sides of this application in its entirety for your child to be considered for enrollment at St. Peter School. If your child is accepted, you will be contacted by the school office with information on next steps. If a class is full, you will be notified of your child's placement on a waiting list.

Child's Name: _____ Grade:_____
Last First M.I.

Nickname: _____

Address: _____
City Zip

Phone:_____ SSN:_____

Preferred Email: _____

Date of Birth:_____ Gender:_____ Child's Religion:_____

Ethnicity:_____ Place of Birth:_____
Hospital City

Did your child attend preschool?_____ If yes, where?_____

Was your child on an IEP?_____ If yes, please explain:_____

Baptism: _____
Church City Month Day Year

Church Affiliation:_____

School District You Reside In:_____

Father's Name:_____ Religion:_____

Work Place:_____ Phone:_____

Mother's Name:_____ Religion:_____

Work Place:_____ Phone:_____

Parent Marital Status (check one): _____Single _____Married _____Divorced _____Separated
Child/Children live with:_____Mother _____Father _____Both
(If divorced/separated–School will need a copy of custody papers)

Other Children in the Family:_____Grade:_____
_____Grade:_____
_____Grade:_____
_____Grade:_____

In the space below, please share why you have chosen St. Peter School for your child.

_____
_____
_____
_____
_____
_____

What should we know about your child that would help us to better serve his/her growth?

_____
_____
_____
_____
_____
_____

What do you hope to receive from becoming a part of the St. Peter Catholic School family?

_____
_____
_____
_____
_____
_____

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name		Sex ☐ Male ☐ Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL

Tuberculin Test

Date _____ Type _____ Results _____

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

- ☐ Examination
- ☐ Orthodontic assessment
- ☐ Fluoride application
- ☐ Radiographs
- ☐ Oral prophylaxis (cleaning)
- ☐ Dental sealant
- ☐ Prescription for fluoride supplement
- ☐ Treatment (restoration, pulp therapy)
- ☐ Other _____

The following oral hygiene instruction was provided (please check all that apply)

- ☐ Toothbrushing
- ☐ Flossing
- ☐ Dietary counseling
- ☐ Use of fluoride mouthrinse
- ☐ Other _____

The following statements are applicable (please check all that apply)

- ☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ Further treatment is indicated.(See comments)
- ☐ Further appointments have been arranged. (Orthodontic, restorative)
- ☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP