Diocese of Erie
Application Form
Elementary and Middle Schools

Name of School: Saint Gregory Parish School, 140 West Main Street, North East, PA 16428 City: ______

Dear Parents/Guardians,

Thank you for your interest in a Catholic school in the Diocese of Erie where excellence in education is a tradition. With faith in Jesus Christ and commitment to living and teaching Gospel values, we educate the student spiritually, intellectually, emotionally, physically, and socially.

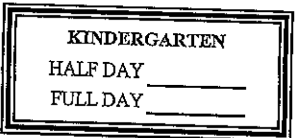
Please complete this application and return it to the school office. Once all necessary documents have been received, your application will be reviewed and you will be contacted. All information will be held confidential according to the Family Educational Rights and Privacy Act (FERPA) regulations. Completion of this application does not guarantee enrollment. In addition, it should be noted that based on a review of the data received through this application process, the student may be accepted on a provisional basis for a specified time period.

Thank you again for your interest in Catholic education.

Mr. James Gallagher
Superintendent of Catholic Schools

Rev. August 2021

Please **PRINT** all information.


KINDERGARTEN
HALF DAY ______
FULL DAY ______

CHILD INFORMATION

Date ____________________

Name ____ Male ____ Female ____ Grade Child Would Be Entering ________
LAST FIRST MIDDLE

Date of Birth ___/___/___ Birth Certificate No. ____________ Place of Birth ____________________ Religion ________
MONTH DAY YEAR CITY STATE

Address ____ Phone ________
HOUSE NO. STREET APT. NO. LOT NO. CITY STATE ZIP CODE

Child lives with: (Please Check) Both Parents ____ Mother ____ Father ____ Other ____ Legal Custody with ____________ **(Must have Court Papers)**

Baptism ____
DATE CHURCH LOCATION CERTIFICATE VERIFIED

First Eucharist ____
DATE CHURCH LOCATION CERTIFICATE VERIFIED

Public School District of Residence ________ School Last Attended ____________________ From Grade ____ to Grade ____
NAME ADDRESS CITY STATE ZIP CODE

List all schools the child has previously attended	Grade(s)	Year(s)

Did child ever repeat a grade? No ____ Yes ____
Does child have difficulty learning? No ____ Yes ____
Does child have any behavioral problems No ____ Yes ____

List all auxiliary services child has received: (e.g., Title I, Speech Therapy, Act 89) ____________________

Check all special programs child has attended: ____ Counseling ____ Early Intervention ____ ELL/ESL ____ Emotional Support ____ Gifted ____ Learning Support
____ Life Skills ____ Mental Health ____ Remedial ____ Wraparound ____ Other ____________

Has child previously been offered an Individualized Education Program (IEP)? No ____ Yes ____ If yes, list date/grade ________ Chapter 15 - 504 Plan? No ____ Yes ____ If yes, list date/grade ________

What language(s) does the child speak? ____________ What language(s) is spoken in the home? ____________

FAMILY INFORMATION

	FIRST/LAST NAME	HOME ADDRESS	EMPLOYER'S NAME	WORK ADDRESS	WORK PHONE	HOME PHONE	CONTRIBUTING PARISHIONER OF:
FATHER							
MOTHER							
STEP-PARENT							
STEP-PARENT							
OTHER							

Other Children Living in Home

FIRST/LAST NAME	RELATIONSHIP TO APPLICANT	BIRTHDATE

Child's Physical Description at Time of Application.

EYE COLOR	HAIR COLOR
HEIGHT	WEIGHT

Rev. August 2021

HEALTH INFORMATION

Original immunizations records are required. The school will make copies to insert in the application.

Does child have health insurance coverage? No ________ Yes ________

Name of Physician or Clinic: ____________________ Phone Number: ____________________

Has child ever had surgery? No ________ Yes ________

Type of Operation: ____________________ Date: ____________________

Does child have allergies? No ________ Yes ________ Type: ____________________

Allergy Medication: ____________________

Does child have allergies to any medication? No ________ Yes ________ Type ____________________

List prescription medications child is currently taking: ____________________

Medical Conditions:

Diabetes: No ______ Yes ______ Heart Problems: No ______ Yes ______

Epilepsy: No ______ Yes ______ Asthma: No ______ Yes ______

Other: ____________________

Records were copied on: ____________________
DATE

Initials: ____________________

OTHER INFORMATION

In order to properly plan for an incoming student, the school needs to know if there is any educational, developmental, psychological, behavioral, social, or medical history that affects the student's learning.

	Please check No or Yes.		If Yes, please briefly describe.
Special Educational Program:	No ______	Yes ______	
Early Intervention Program:	No ______	Yes ______	
Educational History:	No ______	Yes ______	
Developmental History:	No ______	Yes ______	
Psychological History:	No ______	Yes ______	
Medical History:	No ______	Yes ______	
Physical Conditions:	No ______	Yes ______	
Other:	No ______	Yes ______	

By placing my signature below, I (we) verify that all information is accurate and complete. I (we) realize that failure to provide accurate information about my (our) child may jeopardize enrollment at this school. I (we) further verify that no information has been omitted.

PARENT/GUARDIAN SIGNATURE ____________ PLEASE PRINT NAME ____________ DATE ____________

PARENT/GUARDIAN SIGNATURE ____________ PLEASE PRINT NAME ____________ DATE ____________

For School Use Only

______ REGISTRATION ACCEPTED

______ REGISTRATION PROVISIONALLY ACCEPTED

______ REGISTRATION DENIED

____
DATE

____
PRINCIPAL SIGNATURE

While reserving the right to make religious exceptions as provided by law and in accord with Catholic religious belief, the Catholic schools within the Diocese of Erie do not discriminate on the basis of sex. This includes being excluded from participation in, being denied the benefits of, or being subjected to discrimination under any education program or activity on the basis of sex.

Title IX Information can be found at www.eriercd.org/schools/titleix.html

Pennsylvania School Code 13-1304-A states in part: "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction or injury to another person, or for any act of violence committed on school property."

Please complete the following:

I hereby swear or affirm that my child ____________________, (circle one) was/ was not previously suspended or expelled from any public or private school of the Commonwealth of Pennsylvania or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction or injury to another person or for any act of violence committed on school property.

School from which student was suspended/expelled ____________________

Dates of suspension/expulsion ____________________

Reason(s) for suspension/expulsion ____________________

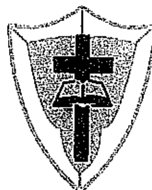
____

I understand that this form shall be maintained as part of the student's disciplinary record. I further understand in making this statement that I am subject to penalties under 24 P.S. 13-1304-A9b and 18 Pa.C.S.A.4904 relating to falsification to authorities, and that any willful false statement made on this form shall be a misdemeanor of the third degree.

I swear or affirm that the facts contained herein are true and correct to the best of my knowledge, information and belief.

____________________ ____________________

DATE SIGNATURE

ST. GREGORY  PARISH SCHOOL

"WHERE FAITH AND KNOWLEDGE MEET."

Home Language Survey

Used to determine a primary or home language other than English.
Please type or print all responses.

Student's Name: ______________________________

Student's Date of Birth: ______________________________

Student's Age: ______________ Student's Grade: ______________

Country of Origin: ______________________________

List Other Countries of Residence: ______________________________

____

Parent/Guardian's Name: ______________________________

Parent/Guardian's Telephone Number: ______________________________

#1. What was the first language your child learned to speak? ______________

#2. Does your child speak a language other than English? ______________
If yes, what is that language(s)? ______________________________
(Do not include the language learned at school.)

#3. What language(s) is/are spoken in your child's home? ______________
____

Survey Conducted/Completed By: ______________________________

Parent/Guardian's Signature: ______________________________

Date: ______________________________

Do NOT include Foreign Exchange Students – this does not apply to them.

Place in student's Permanent Record Folder. Rev. March 2009

NORTH EAST SCHOOL DISTRICT
HEALTH HISTORY

THIS FORM MUST BE COMPLETED
(ONE FORM PER STUDENT)

STUDENT NAME_______________________________________ Gender _Male___Female

Date of Birth__________________Place of Birth_______________________________________

Current Address____Phone ______________

Parent's/Guardian's Names _

Grade__________School Last Attended ____

Family Physician____Phone __________________

Is your water supply from the North East Borough? Yes _______ No _______

If NO, has your child had fluoride treatments? _______________________________________

HEALTH HISTORY: Please list any serious illnesses or communicable diseases: _________________

____

Allergies? ____

IMMUNIZATION HISTORY: Please list dates or attach Doctor's print out.

DPT (Combination Diphtheria-Pertussis-Tetanus) – 4 Required
1)_____________2)____________3)_____________4)____________Booster ____________

MCV 1) ____________ TDAP 1) _____________

POLIO-SABIN VACCINE – 4 Required
1)____________2)____________3)_____________4)_____________Booster __________

MMR (Combination Measles-Mumps-Rubella) – Required 1) ______________ 2) ______________

HEPATITIS A 1)_______________2) _______________

HEPATITIS B – 3 Required 1)_______________2)_______________3) ______________

HIB VACCINE – 3 Required 1)_______________2)_______________3) ______________

If applicable:
CHICKEN POX (Date child had chicken pox)________________OR
VACCINE 1)___________________2) __________________

(Continued on back)

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name ______________________ Today's date__________

Date of birth __________ Age at time of exam______ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

____

____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student...*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other______		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student...*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:______		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? ______ Date of last period: ______		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: ______ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other______		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other______		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student________________________ Date__________

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT NAME:

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam__________20_____

Print name of examiner ____

Print examiner's office address______________________________ Phone_______________

Signature of examiner______________________________ MD ☐ DO ☐ PAC ☐ CRNP ☐

 STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

Medical ☐ Date Issued:__________ Reason: ______________________________ Date Rescinded:__________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	**DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization**				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:__________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)

STUDENT NAME:

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL Saint Gregory School ______ DATE ______ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

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

Catholic Schools Office
Diocese of Erie

REQUEST FOR HEALTH AND SCHOOL RECORDS

I hereby certify that ______________________________ entered the ________ Grade in St. Gregory School ______ School on the ________ day of __________, 20____. Please forward the Health and Academic Records and the last attendance date for this student.

Nancy Pierce (HO)
Principal's Signature

140 W. Main St.
Address of School

Date ________________ North East, PA 16428
814-725-4571
814-725-4572 (Fax)

You are hereby authorized to transfer the Health and Academic Records of

______________________________ to St. Gregory School
Name of Student Name of School

I do ________ do not ________ wish to receive a copy of the above school records.

The student is my son ________, my daughter ________, legal ward ________.

____
Parent's/Guardian's Signature

____
Address

Date ________________ ______________________________