



284 East Main Street
 Smithtown, NY 11787
 631-724-0285
 www.spssmith.org

4-8 Application Packet

Application for Admissions

Date of Application: ___/___/___

Student Full Name:			
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Last Name

First Name

Middle Name

Entering Grade (circle one):

4

5

6

7

8

Address:			
Town:	State:	Zip:	
Date of Birth:	Place of Birth:	Gender:	
Home Phone #			

Ethnicity: (must select one):		Home Parish:	
Hispanic, Latino, or of Spanish Origin	<input type="checkbox"/>	Home Parish: (city/state)	
Not Hispanic, Latino, or of Spanish Origin	<input type="checkbox"/>	Students Religion:	
RACE (must select at least one):		Baptized: <input type="checkbox"/> Yes (date: _____) <input type="checkbox"/> No	
African American	<input type="checkbox"/>	Baptism Church Name:	
American Indian / Alaskan Native	<input type="checkbox"/>	Baptism Location: (city/state)	
Asian	<input type="checkbox"/>	Home Language:	
Caucasian	<input type="checkbox"/>	Home Public School District:	
Native Hawaiian / Pacific Islander	<input type="checkbox"/>		

Student Resides with? Both Parents Mother Father Grandparent Other: _____

Father's Information

Full Name:			
<i>First Name</i>	<i>Last Name</i>		
Business Address:			
Town:	State:	Zip:	
Occupation	Religion:	Place of Birth:	
Daytime Phone	Cell Phone		
Email:	Custody:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Living <input type="checkbox"/> Deceased <input type="checkbox"/>

Mother's Information

Full Name:			
<i>First Name</i>	<i>Last Name</i>	<i>Maiden Name</i>	
Business Address:			
Town:	State:	Zip:	
Occupation	Religion:	Place of Birth:	
Daytime Phone	Cell Phone		
Email:	Custody:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Living <input type="checkbox"/> Deceased <input type="checkbox"/>

Reservation Fee \$ 150.00

Registration Fee \$ 50.00

Total (Non-Refundable) \$ 200.00



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Additional Information for Admissions

Student Full Name:			
	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>

Education			
Does Student have IEP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does Student have Section 504?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Previous School Attended			
School Name:		City:	State:
Years Attended:			

Sibling Information (Please list the name(s)/age/gender of siblings)			
<i>First Name</i>	<i>Last Name</i>	<i>Age</i>	<i>Gender</i>

Guardian Information (Complete if Student's lives with someone other than Father/Mother)			
Full Name:			
	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>
Address:			
Town:		State:	Zip:
Daytime Phone		Cell Phone	
Email:		Custody:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Person Responsible for Tuition			
Full Name:			
	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>
Address:			
Town:		State:	Zip:
Daytime Phone		Cell Phone	
Email:			

Referred by:
<i>Last Name</i>



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RELEASE AUTHORIZATION

Dear Parent/Guardian:

Recent State legislation now requires schools to maintain a list of persons to whom the school may release a minor. As the child's parent/guardian, you are required to indicate the names of those people, other than yourself, to whom your child may be released. If a student is to be released to an older brother or sister, the name of that sibling must also appear on the list below. Please be sure to also include in this list the people you have identified for emergency notification on your child's health card.

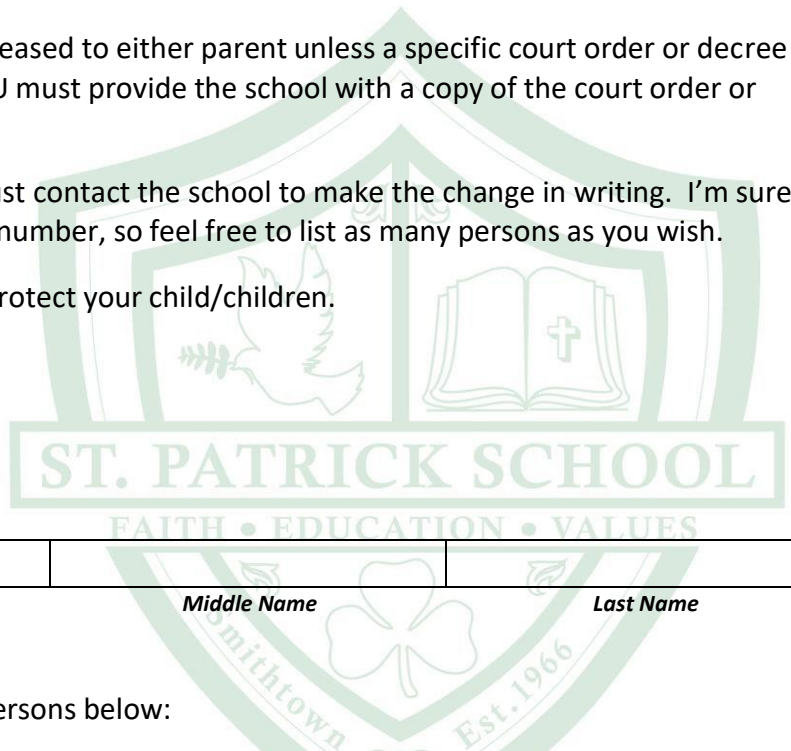
Please note that under this law a child is to be released to either parent unless a specific court order or decree indicates otherwise. Should this be the case, YOU must provide the school with a copy of the court order or decree.

If at any time you wish to amend this list, you must contact the school to make the change in writing. I'm sure you will agree that two persons is an insufficient number, so feel free to list as many persons as you wish.

Thank you for your cooperation in this effort to protect your child/children.

Sincerely,

Barbara Pellerito, Principal



Student Full Name:			
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First Name

Middle Name

Last Name

Child may be released to any of the authorized persons below:

Name	Address	Phone #	Relationship

Parent Signature		Date:	
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Authorization for Release of Student Records

Date: ___/___/___

School Name:					
Address:					
City		State		Zip	

Student Full Name:			
	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>

Current Grade:		Date of Birth:	
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Authorization is granted by the undersigned for the release of all official records, files and data directly to the student named hereon to:

Saint Patrick School
 284 East Main Street
 Smithtown, NY 11787
 Attention: Mrs. Kaminsky

Signature of Parent or Guardian	
Principal	Barbara Pellerito



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4 -8th Health History

Today's Date: ___/___/___

Student Full Name:			
	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>
Date of Birth:		Gender:	
Your Name	Relationship to Child:		

Please check the illness your child has had:		Dates if possible
1. Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Communicable Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Tuberculosis or contact w/T.B.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Last T.B. Test		Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Hospitalizations and Illnesses		Explain "YES" Answers
10. Has child ever been hospitalized or operated on?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Has child ever had a serious accident (broken bones, head injuries, falls, burns or poisoning)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Has child ever had a serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Health Problems		Explain "YES" Answers
13. Does child have frequent <input type="checkbox"/> sore throat <input type="checkbox"/> cough <input type="checkbox"/> urinary infections or trouble urinating <input type="checkbox"/> stomach pain, vomiting, diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Does child have difficulty seeing (squint, cross eyes, look closely at books).	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, was last checkup more than one year ago? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Is child wearing (or supposed to wear) glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Does child have problems with ears/hearing (pain, earaches, discharge, rubbing one ear)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Is child taking any other medicine now? (Special consent form must be signed to administer any medication)	<input type="checkbox"/> Yes <input type="checkbox"/> No	What Medicine? Will it be given while child is at school? <input type="checkbox"/> Yes <input type="checkbox"/> No How often?



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4 -8th Health History – Continued

Student Full Name:					
		<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>	
18. Does child have any allergy problems (rash, itching, swelling difficulty breathing, coughing or sneezing)? <input type="checkbox"/> When eating any foods? <input type="checkbox"/> When taking any medication? <input type="checkbox"/> When near animals, furs, insects, dust, etc.?			If YES please explain. What foods? What medicine? What things? How does child react?		
19. Does child have Scoliosis?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:		
20. Any handicapping conditions?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:		
21. Any Further information regarding your child that will assist us in His/Her Care:					
Parent's Signature:				Date:	



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Important Information

Student Full Name:											
	<i>First Name</i>		<i>Middle Name</i>		<i>Last Name</i>						
Grade (circle one):	N	Pre-K	K	1	2	3	4	5	6	7	8
Address:											
Town:					State:			Zip:			
Date of Birth:				Place of Birth:				Gender:			
Home Phone #											
Home Public School District:											

Father's Information

Full Name:											
	<i>First Name</i>		<i>Middle Name</i>		<i>Last Name</i>						
Business Address:											
Town:					State:			Zip:			
Occupation				Religion:			Place of Birth:				
Daytime Phone					Cell Phone						
Email:											

Mother's Information

Full Name:											
	<i>First Name</i>		<i>Middle Name</i>		<i>Maiden Name</i>						
Business Address:											
Town:					State:			Zip:			
Occupation				Religion:			Place of Birth:				
Daytime Phone					Cell Phone						
Email:											

Health Care Information

Dentist Name:			Phone #		
Physician's Name:			Phone #		

Minimum requirements for school attendance in New York State:

Immunizations: A doctor's certification must accompany this form indicating:

N, PK	3 Diphtheria (DTAP, DTP), 3 OPV or 4 IPV, 1 measles, 1 mumps, 1 rubella
	3 HIB (or HIB if administered on or after 15 months of age)
	3 Hepatitis B for children born on or after 1/1/95
	1 dose Varicella for children born on or after 1/1/00
K-12	3 Diphtheria (DTAP, DTP), 3 OPV or 4 IPV, 2 measles, 1 mumps, 1 rubella
	3 Hepatitis B
	1 dose Varicella for children born on or after 1/1/98