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:			
	Last Name	*First Name*	*Middle Name*

Entering 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 #					

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

Student Resides with? ❑ *Both Parents* ❑ *Mother* ❑ *Father* ❑ *Grandparent* ❑ *Other:*__________________

Father's Information						
Full Name:						
	First Name	*Last Name*				
Business Address:						
Town:		State:		Zip:		
Occupation		Religion:		Place of Birth:		
Daytime Phone		Cell Phone				
Email:		Custody:	❑ Yes ❑ No	Living ❑	Deceased ❑	

Mother's Information						
Full Name:						
	First Name	*Last Name*	*Maiden Name*			
Business Address:						
Town:		State:		Zip:		
Occupation		Religion:		Place of Birth:		
Daytime Phone		Cell Phone				
Email:		Custody:	❑ Yes ❑ No	Living ❑	Deceased ❑	

Reservation Fee $ 150.00 *Registration Fee $ 50.00* *Total (Non-Refundable) $ 200.00*

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Additional Information for Admissions

Student Full Name:			
	First Name	***Middle Name***	***Last Name***

Education			
Does Student have IEP?	❑ Yes ❑ No	Does Student have Section 504?	❑ Yes ❑ No

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

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

Guardian Information (Complete if Student's lives with someone other than Father/Mother)					
Full Name:					
	First Name	*Middle Name*		*Last Name*	
Address:					
Town:		State:		Zip:	
Daytime Phone		Cell Phone			
Email:		Custody:	❑ Yes ❑ No		

Person Responsible for Tuition					
Full Name:					
	First Name	*Middle Name*		*Last Name*	
Address:					
Town:		State:		Zip:	
Daytime Phone		Cell Phone			
Email:					

Referred by:
Last Name

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4-8 Application Packet

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.

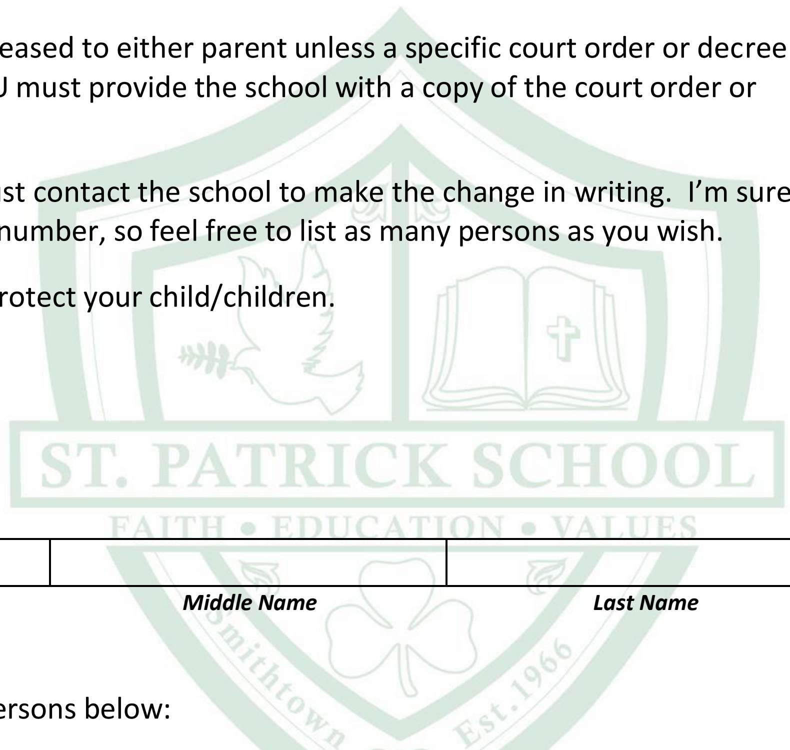
Please note that under this law a child is to be released to either parent unless a specific court order or decree indicates otherwise. Should this be the case, YOU must provide the school with a copy of the court order or decree.

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,

Linda Pymm, Principal



Student Full Name:			
	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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4-8 Application Packet

Authorization for Release of Student Records

Date: ___/____/____

School Name:					
Address:					
City		State		Zip	

Student Full Name:			
	First Name	***Middle Name***	***Last Name***

Current Grade:		**Date of Birth:**	

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	Linda Pymm

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4 -8th Health History

Today's Date:____/____/____

Student Full Name:			
	First Name	***Middle Name***	***Last Name***

Date of Birth:		Gender:	
Your Name		Relationship to Child:	

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

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4 -8th Health History – Continued

Student Full Name:			
	First Name	***Middle Name***	***Last Name***

18. Does child have any allergy problems (rash, itching, swelling difficulty breathing, coughing or sneezing)? ❑ When eating any foods? ❑ When taking any medication? ❑ 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?	❑ Yes ❑ No	Explain:
20. Any handicapping conditions?	❑ Yes ❑ No	Explain:

21. Any Further information regarding your child that will assist us in His/Her Care:	
Parent's Signature:	Date:

ST. PATRICK SCHOOL
FAITH • EDUCATION • VALUES
Smithtown Est. 1966

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4-8 Application Packet

Important Information

Student Full Name:			
	First Name	*Middle Name*	*Last Name*

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:			
	First Name	*Middle Name*	*Last Name*

Business Address:					
Town:		State:		Zip:	
Occupation		Religion:		Place of Birth:	
Daytime Phone		Cell Phone			
Email:					

Mother's Information

Full Name:			
	First Name	*Middle Name*	*Maiden Name*

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