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

N-3 Application Packet

Application for Admissions

Date of Application: ___/___/___

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

Entering Grade (circle one): N 3 ½ days 3 full days Pre-K 3 ½ days 3 full days K 1 2 3
N 5 ½ days 5 full days Pre-K 5 ½ days 5 full days

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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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:			
	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:			
	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	Barbara Pellerito

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N – 3 Health History

Today's Date:____/____/____

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

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

Pregnancy / Birth History		**Explain "YES" Answers**
1. Did mother have any health problems during this pregnancy or delivery?	❑ Yes ❑ No	
2. Was child born more than 3 weeks early or late?	❑ Yes ❑ No	
3. What was child's birth Weight?		**lbs oz**
4. Was anything wrong with child in the nursery?	❑ Yes ❑ No	
5. Did child or mother stay in hospital for medical reasons longer than usual?	❑ Yes ❑ No	
Hospitalizations and Illnesses		**Explain "YES" Answers**
6. Has child ever been hospitalized or operated on?	❑ Yes ❑ No	
7. Has child ever had a serious accident (broken bones, head injuries, falls, burns or poisoning?	❑ Yes ❑ No	
8. Has child ever had a serious illness?	❑ Yes ❑ No	
Health Problems		**Explain "YES" Answers**
9. Does child have frequent ❑ sore throat ❑ cough ❑ urinary infections or trouble urinating ❑ stomach pain, vomiting, diarrhea	❑ Yes ❑ No	
10. 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
11. Is child wearing (or supposed to wear) glasses?	❑ Yes ❑ No	
12. Does child have problems with ears/hearing (pain, earaches, discharge, rubbing one ear)?	❑ Yes ❑ No	
13. Has child ever had a convulsion or seizure? Is child taking medicine for seizures?	❑ Yes ❑ No	If YES, When did it last happen?___/___/____ What Medicine?
14. 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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N – 3 Health History – Continued

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

15. Is child now being treated by a physician or a dentist?
Physician's Name:_____Phone:_____

Dentist's Name:_____Phone:_____

16. Has child had: (Please check:)
❑ Chicken Pox ❑ German Measles ❑ Measles ❑ Mumps ❑ Eczema
❑ Scarlet Fever ❑ Whooping Cough

17. Has child had: (Please check:)
❑ Bleeding Tendencies ❑ Epilepsy ❑ Liver Disease ❑ Heart/Blood Vessel Disease ❑ Sickle Cell Disease
❑ Rheumatic Fever ❑ Asthma ❑ Diabetes
If YES, please explain:

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 your child take a nap? ❑ Yes ❑ No	Describe when and how long.

20. Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late? ❑ Yes ❑ No
If YES describe arrangements (own room, own bed and so forth)

21. How does your child tell you he/she has to go to the toilet?

22. Does your child need help in going to the toilet during the day or night, or does your child wet his/her pants?
❑ Yes ❑ No If YES please describe:

23. Children learn to do things at different ages. We need to know what each child already can do or is learning to do easily and where they might be slow or need help.

	Age Completed:		**Age Completed:**
a) Sit up without Help		b) Talk	
c) Crawl		d) Feed & Dress Self	
e) Walk		f) Learn to Use Toilet	

24. Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? ❑ Yes ❑ No If YES please describe:

Parent's Signature:	Date:

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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