REGISTRATION PACKET

WELCOME

TO

ST. TIMOTHY SCHOOL

1070 Thomas Lane

Columbus, Ohio 43220

Office Phone Number: (614)451-0739

Website: www.sttimschool.org

Diocese of Columbus

PERMANENT RECORD FOR: _____ _____ _____

Last Name First Name Middle Name

SOCIAL SECURITY NUMBER: _____

PARISH: _____

CATHOLIC ☐ NON-CATHOLIC ☐	SEX	BIRTHDATE	BIRTHPLACE	
	MALE ☐ FEMALE ☐			
		Month/Date/Year	CITY	STATE

RESIDENCE:				
STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE

⇩YOU ARE NOT REQUIRED TO ANSWER THIS QUESTION⇩

RACE: ☐ WHITE ☐ BLACK, NOT HISPANIC ☐ HISPANIC

☐ ASIAN PACIFIC ☐ AMERICAN INDIAN/ALASKAN NATIVE

FAMILY:	FATHER OR GUARDIAN	MOTHER (MAIDEN)		
FATHER'S BIRTHPLACE	RELIGION	EDUCATION	TYPE OF OCCUPATION	
FATHER'S WORK	BUSINESS ADDRESS	TELEPHONE NUMBERS		
		(H)	(W)	(C)
MOTHER'S BIRTHPLACE	RELIGION	EDUCATION	TYPE OF OCCUPATION	
MOTHER'S WORK	BUSINESS ADDRESS	TELEPHONE NUMBERS		
		(H)	(W)	(C)

HOME STATUS	STUDENT LIVES WITH:	# OF CHILDREN IN FAMILY			
Check if any apply: ☐ SINGLE ☐ PARENTS SEPARATED ☐ FATHER DECEASED ☐ PARENTS DIVORCED ☐ MOTHER DECEASED ☐ IF SEPARATED OR DIVORCED A COPY OF CUSTODY PAPERS HAS BEEN PROVIDED TO THE SCHOOL	☐ BOTH PARENTS ☐ OTHERS ☐ FATHER ☐ STEP-FATHER ☐ MOTHER ☐ STEP-MOTHER	BOYS		GIRLS	
		OLDER	YOUNGER	OLDER	YOUNGER

SACRAMENTS:

BAPTISM					
FIRST COMMUNION					
RECONCILIATION					
CONFIRMATION					
	MO/DAY/YR	CHURCH	STREET	CITY	ST

ENTRANCE AND WITHDRAWL:

MO/DAY/YR	ADMITTED FROM	GRADE	MO/DAY/YR	TRANSFERRED TO	GRADE	CAUSE

GRADUATION DATE: HIGH SCHOOL ENTERED:

ST. TIMOTHY SCHOOL

Child's name:	Requested admission date:
Address:	Phone Number:
Mother's name:	Father's name:
Mother's email	Father's email:
Parental Status:	Number of children in family:
☐ Married ☐ Separated ☐ Divorced	

Identify your church affiliation:

How would you describe your involvement in the parish?

How would you describe your child's academic performance?

How would you describe your child's general motivation?

Generally how hoes your child get along with

Peers:

Adults:

Please list your child's strengths:

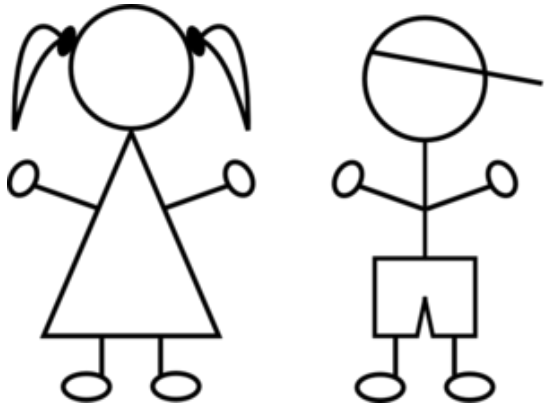
Please describe your child's weaknesses:

REGISTRATION PACKET

(Part 2)

ST. TIMOTHY SCHOOL

Printable Health History Forms



1070 Thomas Lane

Columbus, Ohio 43220

Office Phone Number: (614)451-0739

Website: www.sttimschool.org

Memo: All incoming new students and parents

Subject: Health requirements

From: School Nurse

In order to provide all pertinent State of Ohio and Diocesan requirements for health records of your students, please provide the information on the enclosed Ohio Health History form. There are three parts to this form, a parent form, a signed and dated physical form from your physician, and a signed and dated dental form from your dentist.

Please be aware that the State of Ohio has changed the immunization scheduled for some vaccinations effective fall 1999, with exclusion of students not meeting these requirements for fall 2000. The new additional vaccinations for kindergarten and first grade include:

- A 2nd MMR (measles, mumps and rubella)
- A 5th DPT (if fourth dose was before age four)
- A 4th Polio (if the third dose was before the age of four)
- The Hepatitis B series (3 doses: 2nd doses at least 28 days after the first, and the 3rd does by at least 4 months)

Please consult with your physician regarding this information and try and start early so all vaccines can be administered by fall.

Please provide the information to the school office when it is completed so we can have it on file for the first day of school. Feel free to send it anytime between now and fall.

Please note: *If your student is transferring to first grade from another diocesan school, we can accept those kindergarten records to meet these requirements and those records should be transferred by those schools.*

Thank you for your help.

Ohio School Health History Form

Parent Form

School: _____

Enrolled: _____ *Grade*: _____

D.O.B: _____/_____/_____

_____

Student's Last Name First Name Middle Name

_____

Student's Address

_____

Parent/Legal Guardian Address if different from above

_____

Home Phone Work Phone Cell Phone

Form Completed by: _____ Relationship to Child: _____

Family History: Please list names of all Child's family members, including parents and siblings

Name	Birthdate	Health Concerns? YES or NO	Is the child in school this year? YES or NO	If so, where?
1.				
2.				
3.				
4.				
5.				
6.				

Allergies

Please list and describe allergies or reactions.

Medication/Drugs
Food/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses and Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures

Injuries/Illness/Hospitalization	Age	If hospitalized, please explain

Medical Information

Please describe any medications that your child takes daily or frequently

Name of Medication	What is the medication for?	How often and what time(s) is medication taken?

Please add any comments or concerns you have about our child's health, development, behavior, family or home life that you would like us to be aware of.

_____

_____

_____

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

___ Abnormal spinal curvature
___ Allergies/hay fever
___ Anemia
___ Anaphylactic reaction
___ Asthma or wheezing
___ Attention Deficit Disorder
___ Autism
___ Behavioral Problems
___ Birth or congenital malformation
___ Cancer
___ Chronic diarrhea or constipation
___ Chronic ear infection
___ Concern about relation with siblings or friends
___ Cystic Fibrosis
___ Diabetes
___ Eczema/Chronic skin conditions
___ Emotional problems
___ Eye problems, poor vision

___ Heart disease
___ Hemophilia
___ Hepatitis
___ HIV positive
___Hyperactivity
___ Kidney disease
___ Measles
___ Meningitis or Encephalitis
___ Mumps
___ Nervous twitches or tics
___ Poisoning
___ Rheumatic fever
___ Seizure disorder
___ Sickle Cell disease
___ Speech difficulties
___ Urinary infections
___ Other:

Ohio School Health History Form

Physical Assessment Form

School: _____

Date Enrolled _____ Grade _____

Student's Legal Last Name	First Name	Middle Name	

Date of Physical Examination: _____ **Today's Date:** _____

Screening Data

Vision Date:				Hearing Date:			
Distance Acuity Right _____ Left _____				Pure tone testing:			
Muscle Balance	Pass	Fail	Not done	Right ear	Pass	Fail	Not done
Stereopsis	Pass	Fail	Not done	Left ear	Pass	Fail	Not done
Color	Pass	Fail	Not done	Student wears hearing aid?		Yes	No
Student wears glasses?		Yes	No	Testing with hearing aid?		Yes	No
Tested with glasses?		Yes	No	Referral made?		Yes	No
Referral made?		Yes	No	Other test (specify)			

Speech Assessment Date: _____

Student has no discernable speech problems

Student has possible problem with: (Circle all that apply) Articulation Rhythm Voice Language

Speech evaluation is recommended: Yes No

Objective Data

Height	Weight	BP
Laboratory Tests:		
☐ Hemoglobin/Hematocrit ☐ Urine Protein ☐ Urine Blood ☐ Urine Glucose ☐ Other: _____		

Physical Exam:

☐ Physical Exam essentially was within normal limits

☐ Physical Exam is *not* within normal limits.

Explain:

_____

_____

Does this student have any physical, developmental, or behavioral problems? YES NO

If yes, please suggest special programs, placement or attention the school can provide.

_____

Activities and Limitations

Can the student participate fully in the following activities?

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

Medications: Is this student on any medications? Yes No

Explain: _____

Examiner's Signature: _____ Date Signed _____

_____

Examiner's Printed Name

Address: _____Phone #: _____

Immunizations

Please list the dates of the following immunizations (month/date/year)

DTaP/DT Tdap/Td						
Polio						
MMR						
Hepatitis B						
Varicella (chicken pox)						
Hepatitis A						
Hib						
Influenza (yearly)						

Tuberculin Test

Date:	Type:	Results:
Date:	Type:	Results:

Note: A copy of your child's immunizations record may be attached to this form.

Source of information: (check one)

_____ Parent/Legal Guardian
_____ Physician's Office
_____ Local Health Department
_____ Other (specify) _____

_____

Signature of person providing information

_____

Date

Ohio School Health Oral Assessment Form

School: _____ Date Enrolled: _____ Grade: _____

_____

Student's Legal Last Name First Name Middle Name

Student's address: _____ Age: _____

_____ Date of Birth: ____ /____ /____

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

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

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

- ☐ Toothbrushing
- ☐ Flossing
- ☐ Dietary Counseling
- ☐ Home/School use of fluoride mouth rinse
- ☐ Other: _____

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

- ☐ All necessary preventative services have been performed (fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ No further treatment is indicated (see comments)
- ☐ Further appointments have been arranged (ex. Orthodontics, restorative)
- ☐ Routine recall visits recommended

Comments:

Dentist's Signature: _____ Date: _____

Dentist's Printed Name: _____

Address:

_____

_____

Phone: _____