

*Learning  
for Life*



St. Dominic School

*Faith  
for Living*

## **REGISTRATION INFORMATION**

### **St. Dominic School**

*309 West Main Street  
Springfield, Kentucky 40069  
859-336-7165 Phone  
859-336-7169 Fax  
[www.stdominicelem.org](http://www.stdominicelem.org)*

# NEW STUDENT REGISTRATION

Last school attended: \_\_\_\_\_

Student's Name: \_\_\_\_\_

last

middle

first

Age: \_\_\_\_\_

Entering grade \_\_\_\_\_ in 20\_\_\_\_ - \_\_\_\_ school year

Pre-registration date: \_\_\_\_\_

Registration date: \_\_\_\_\_

## REGISTRATION MATERIALS CHECKLIST

\_\_\_\_ **Academic Records** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*Transferred from previous school*

\_\_\_\_ **Birth Certificate** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*Copy of state-issued certificate (not hospital certificate);  
transferred w/records from previous school*

\_\_\_\_ **Eye Exam** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*Required for ALL new students; must be completed by an  
optometrist or ophthalmologist (form enclosed)*

\_\_\_\_ **Immunization Certificate** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*Must be up-to-date; transferred w/records from previous school*

\_\_\_\_ **Internet Use/Authorization form** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_

\_\_\_\_ **Media Release/Authorization form** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_

\_\_\_\_ **Medical Authorization form** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_

\_\_\_\_ **Physical Exam** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*ALL NEW STUDENTS & 6TH GRADERS ONLY; must be completed  
at a physician's office; form enclosed*

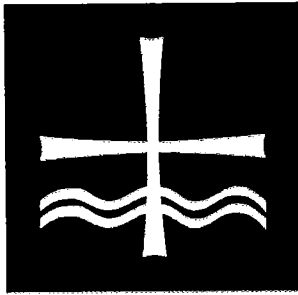
\_\_\_\_ **Sacramental Records** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*If your child is Catholic, we require copies of certificates of all  
sacraments (Baptism, First Communion, First Reconciliation, and  
Confirmation) that your child has received prior to entry at  
St. Dominic School. Our students receive First Communion and  
First Reconciliation in 2nd grade and Confirmation in 8th grade.*

\_\_\_\_ **Social Security Card** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*Transferred w/records from previous school*

\_\_\_\_ **Stewardship Forms** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_  
*School stewardship form must be completed by all school families,  
regardless of whether they are parishioners; parish stewardship and  
intention card must be completed by all parish families.*

\_\_\_\_ **Transportation Form** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_

\_\_\_\_ **Youth Leader/Chaperone Form** *Date received* \_\_\_\_\_ *By* \_\_\_\_\_



# ARCHDIOCESE OF LOUISVILLE

OFFICE OF LIFELONG FORMATION AND EDUCATION  
FLAGET CENTER

1935 LEWISTON DRIVE • LOUISVILLE, KENTUCKY 40216-2569

502-448-8581 • 502-448-5518 (FAX)

E-MAIL: ADMINISTRATION – [OLFE@ARCHLOU.ORG](mailto:OLFE@ARCHLOU.ORG)

Dear Parents,

Thank you for choosing a Catholic school for your child. We are confident that you will truly find “Excellence That You Can Believe In” in our Catholic schools. This quality is manifested daily in our core values of:

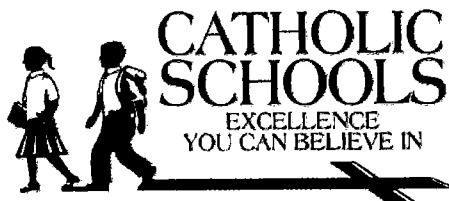
Living Faith  
Celebrating Community  
Embracing Service  
Inspiring Achievement

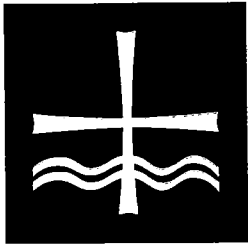
Christ is the foundation for Catholic education, and our students deepen their relationship with Jesus Christ and connect their faith to their daily lives. Catholic schools celebrate community through the spirit of camaraderie that unites people who share common values and goals. As students mature within the supportive environment of Catholic schools, they embrace service by sharing their gifts with the broader community. By inspiring achievement, students excel academically and have the knowledge and skills to be successful today and tomorrow.

We welcome this application for admission of your child to one of the Catholic elementary schools in the Archdiocese of Louisville. We look forward to working with you as partners in your child’s academic and religious formation.

Sincerely,

Leisa Schulz  
Superintendent of Schools





**ARCHDIOCESE OF LOUISVILLE  
CATHOLIC ELEMENTARY SCHOOLS  
STUDENT APPLICATION FORM**

School ST. DOMINIC SCHOOL Parish ST. DOMINIC CHURCH

Current Family Data

	PARENT/GUARDIAN	PARENT/GUARDIAN
Name		
Relationship (Mother, Father, Step-parent, Guardian, Grandparent, Deceased)		
Marital Status (Married, Single, Widowed, Divorced/Remarried, Separated)		
Address		
City/State/Zip		
Home Phone		
Cell Phone		
Work Phone		
E-mail Address		
Religion		
Employer		
Occupation		

Direct Correspondence to: \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Publish in School Directory (Y/N) \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

Names and dates of birth of ALL children in family (list pre-school children first):

Boys \_\_\_\_\_

Girls \_\_\_\_\_

Custody (if applicable): Single (Y/N) \_\_\_\_\_ Name: \_\_\_\_\_

Joint (Y/N) \_\_\_\_\_ Names: \_\_\_\_\_

If you and the physician of your choice, as indicated on back, cannot be reached in an emergency and, if in the judgement of the school authorities, immediate medical and/or hospital attention is indicated, do you authorize the school authorities to send your child (properly accompanied) to an available hospital or physician?

Yes  No Signature of parent or guardian: \_\_\_\_\_

As a parent and/or guardian, I authorize the treatment of a minor child/children by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger child's life, cause physical disability or undue discomfort if delayed. This consent is granted only after reasonable effort has been made to reach me.

Yes  No Signature of parent or guardian: \_\_\_\_\_

**PLEASE FILL OUT THE INFORMATION ON THE BACK**

### STUDENT INFORMATION

Name: \_\_\_\_\_ Child's Social Security \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Birth City/State/Country: \_\_\_\_\_  
 Proposed Grade Placement: \_\_\_\_\_  
 Oldest (Y/N) \_\_\_\_\_ Transportation: \_\_\_\_\_  
 First Language Child Learned to Speak: \_\_\_\_\_  
 Language Child Speaks Most Often: \_\_\_\_\_

**After school, child goes to:**

Place: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Contact: \_\_\_\_\_

**Religious Records:**

Religion: \_\_\_\_\_

SACRAMENT	DATE	CHURCH	CITY/STATE	ZIP
Baptism				
First Eucharist				
First Reconciliation				
Confirmation				

**Health/Emergency Information:**

First Contact/Relation: \_\_\_\_\_ Phone/Cell: \_\_\_\_\_  
 Second Contact/Relation: \_\_\_\_\_ Phone/Cell: \_\_\_\_\_  
 Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Health/Physical Limitations: \_\_\_\_\_  
 Medicine: \_\_\_\_\_  
 Instructions/Allergies: \_\_\_\_\_  
 Immunization Expiration Date: \_\_\_\_\_

**Transferred Information:**

School: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Entered: \_\_\_\_/\_\_\_\_/\_\_\_\_ Withdrew: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Reason code:**

- Codes: 1 - Completed Program                      2 - Moved                      3 - Illness  
           4 - Parent Choice                              5 - Other

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### OTHER EMERGENCY NUMBERS TO CALL

NAME	RELATIONSHIP	HOME	WORK	CELL

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant Historical Information: \_\_\_\_\_

Physical Exam:

N.	Abn.	
_____	_____	General Appearance
_____	_____	HEENT
_____	_____	Skin
_____	_____	Neck
_____	_____	Chest
_____	_____	Heart
_____	_____	Abd - Genitalia
_____	_____	Extremities-Back
_____	_____	Neuro

Hgt: \_\_\_\_\_ Wgt: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_  
Hearing: R \_\_\_\_\_ L \_\_\_\_\_  
Vision: R \_\_\_\_\_ / \_\_\_\_\_ L \_\_\_\_\_ / \_\_\_\_\_  
STRABISMUS/AMBLYOPIA SCREEN  ABNORMAL  
Optional \_\_\_\_\_ HCT/HGB: \_\_\_\_\_ (required for headstart)  
Optional \_\_\_\_\_ UA: \_\_\_\_\_

Explain Abnormal Exam: \_\_\_\_\_

Recommendations:

\_\_\_\_\_ No Restrictions: Normal Exam  
\_\_\_\_\_ RESTRICTIONS AND SUGGESTIONS TO SCHOOL: \_\_\_\_\_  
\_\_\_\_\_

Age appropriate and suggested anticipatory guidance (health assessments)

- Discuss injury prevention with parents
  - Bicycle Safety
  - Car Seat Belts
  - Memorization of Name, Address and Phone Number
- Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.
- Emphasize the importance of dental care.
- Discuss mental health issues.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician/ARNP/PA/EPSTDT Provider

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Archdiocese of Louisville  
Kentucky Eye Examination Form for School Entry**

Effective with the 2004-05 school year, Archdiocese of Louisville Catholic elementary schools require proof of a vision examination by an optometrist or ophthalmologist be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5), or six (6) year old child is enrolled. Vision examination information may be reported on the Kentucky/Archdiocese of Louisville Eye Examination Form for School Entry.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name:	
Date of Birth:	
Parent or Guardian Name:	

**RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230**

CASE HISTORY

Date of Exam: \_\_\_\_\_

Ocular History:    Normal     or Positive for: \_\_\_\_\_

Medical History:    Normal     or Positive for: \_\_\_\_\_

Drug Allergies:    NKDA     or Allergic to: \_\_\_\_\_

Family Ocular and Medical History:     Amblyopia     Strabismus     Glaucoma     Diabetes

Other: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

Refraction with cycloplegic? (please indicate one)     YES     NO

	<u>OD</u>	<u>OS</u>	
Unaided Acuity	20 / _____	20 / _____	
Best Corrected Acuity	20 / _____	20 / _____	
	Normal	Abnormal	Not able to assess
External Exam (eye and adnexa)	o	o	o
Internal Exam (media, lens, fundus, etc.)	o	o	o
Neurological Integrity (pupils)	o	o	o
Binocular Function (stereopsis)	o	o	o
Accommodation and convergence	o	o	o
Color Vision	o	o	o

Saint Dominic School  
309 West Main Street  
Springfield, KY 40069  
Telephone: 859-336-7165  
Fax: 859-336-7169

**REQUEST FOR STUDENT RECORDS**

**TO:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

The following student is enrolling at St. Dominic School for \_\_\_\_\_ school year:

\_\_\_\_\_  
**(Name)** \_\_\_\_\_ **(Address)** \_\_\_\_\_  
**(Birthdate)** \_\_\_\_\_ **(Grade)** \_\_\_\_\_

Please include the following records:

- Report Card
- Withdrawal Grades
- Key to Grading Scale
- Test Scores
- Immunization Record
- Copy of Birth Certificate
- Copy of Social Security Card
- Special Education records, when applicable
  - Full Current IEP
  - Most Recent Evaluation
  - Permission for Initial Evaluation
  - Permission for Initial Placement
  - Last Notice of Proposal/Refusal Action
  - Initial Referral

If parents are separated/divorced, please send copy of custody papers.

Thank you for your prompt attention to this matter.

Sincerely,

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Parent signature, if required