

## REGISTRATION CARD

### STUDENT INFORMATION

DATE: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
                    **Last**                      **First**                      **Middle**

Address: \_\_\_\_\_ NJ \_\_\_\_\_  
                    **Street #**                      **Apt. #**                      **City**                      **Zip Code**

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Personal Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_ U.S. Citizen?      Yes      No

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

Ethnic Background: **Must check at least one from each table.**

Asian	Native Alaskan/American Indian
Black	Native Hawaiian/Pacific Islander
White	

Hispanic
Non-Hispanic

Language(s) spoken at home: \_\_\_\_\_

Elementary school attended: \_\_\_\_\_  
  **Name**    **City**

Have you completed at least 3 academic years in the U.S.?      Yes      No

**(If no, give month/year of entry into U.S. school.)** \_\_\_\_\_

Number of children in family \_\_\_\_\_ Number of children living at home: \_\_\_\_\_

How did you find out about Saint Vincent? **(Check all that apply)**

Website      Open House      Freshman for a Day      Elementary school visit  
Current student or graduate      Teacher/Guidance Counselor      High school night

**PARENT/GUARDIAN INFORMATION**

*The following information must be completed for each parent, stepparent or **legal** guardian.*

Parents are (please check all that apply): Married Divorced Separated Single Mother deceased Father Deceased

Applicant resides with: Both parents Mother Father Stepmother Stepfather  
Legal guardian (indicate relationship) Other(indicate relationship)

**Mother's Name:** \_\_\_\_\_  
Last First

Home Address (If different from Student's):

\_\_\_\_\_  
Street # Apt.# City State Zip code

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Birthplace: \_\_\_\_\_ U.S. Citizen? Yes No Religion: \_\_\_\_\_

Work Phone # : \_\_\_\_\_ Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone # : \_\_\_\_\_ Alt. Email \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  
Last First

Home Address (If different from Student's):

\_\_\_\_\_  
Street # Apt.# City State Zip code

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Birthplace: \_\_\_\_\_ U.S. Citizen? Yes No Religion: \_\_\_\_\_

Work Phone # : \_\_\_\_\_ Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone # : \_\_\_\_\_ Alt. Email \_\_\_\_\_

**Other Name:** \_\_\_\_\_  
Last First

Home Address (If different from Student's):

\_\_\_\_\_  
Street # Apt.# City State Zip code

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Birthplace: \_\_\_\_\_ U.S. Citizen? Yes No Religion: \_\_\_\_\_

Work Phone # : \_\_\_\_\_ Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone # : \_\_\_\_\_ Alt. Email \_\_\_\_\_

**IMPORTANT:** \*Check box in front of individual(s) who should receive e-mail, text or voicemail notifications from school.\*  
**Primary Contact Person** (must have cell phone # & email address): \_\_\_\_\_

**HEALTH HISTORY**  
**AND**  
**PARENT'S CONSENT FORM**

Pupil's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) NJ  
Address \_\_\_\_\_  
School SAINT VINCENT ACADEMY Grade 9 Room \_\_\_\_\_  
Nurse \_\_\_\_\_

Dear Parent or Guardian:

The school physician or school nurse is authorized by the Division of Health to carry out the following procedures for your child provided you sign your name below, and return this form to school.

Administrator's Signature *Sister June Fausta*

Dear Principal:

I wish the above named child, throughout her school life, to be given the following health examination by the school nurse, health examinations, (which will include removal of the shirt above the waist in female pupils): posture inspections, vision and hearing screenings.

I wish to be present for physical examination. Yes ( ) No ( ) If you check "Yes", you will be notified in advance of the screening and will need to make yourself available during the school day.

Signature of Parent or Guardian: \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_

**Health History:**

Is your child currently taking any medicines? \_\_\_\_\_

Type of medicine: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**You will be required to provide doctor's documentation.**

HISTORY	TYPE		TYPE		YEAR
Allergies		Asthma		Chronic Otitis Media (ear infection)	
Congenital Defects		Lyme Disease		Rheumatic Fever	
Drug Allergies		Convulsive Disorder		Strep Infections	
Hepatitis		Diabetes		Mononucleosis	
Neuromuscular Disorder		Heart Disease		Auto Immune Disorders	

OPERATIONS OR INJURIES:	YEAR

Date:

**PLEASE COMPLETE AND RETURN IMMEDIATELY.**

Educational Needs Assessment      Name \_\_\_\_\_

Has your daughter ever been evaluated by a Child Study Team for possible learning differences or other issues that would impact her education? \_\_\_\_\_ Yes (Month/Year): \_\_\_\_\_ No

If yes, what was the outcome/diagnosis/classification assigned? (e.g. Specific Learning Disability, Other Health Impaired, etc.) \_\_\_\_\_

Does she have a current ISP/IEP that details educational accommodations needed? \_\_\_\_\_ Y \_\_\_\_\_ N

**If yes, please send us a copy of her most recent ISP as soon as possible.**

Did your daughter receive Supplemental Instruction services in elementary school? \_\_\_\_\_ Y \_\_\_\_\_ N

If yes, in which grades? \_\_\_\_\_

Compensatory Education? \_\_\_\_\_ Y \_\_\_\_\_ N if yes which grades? \_\_\_\_\_ Subjects? \_\_\_\_\_

Did your daughter receive in-class instructional support from a special education teacher or teacher's aide? \_\_\_\_\_ Y \_\_\_\_\_ N

If yes, in which grades/subjects? \_\_\_\_\_

PLEASE PRINT IN THE SPACES PROVIDED BELOW THE NAME(S) AND COMPLETE ADDRESS (BUILDING AND APARTMENT NUMBERS, IF ANY) OF THE PERSON(S) TO WHOM ALL MAILINGS ARE TO BE SENT:

Date: \_\_\_\_\_

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

Parent/Guardian Name(s) \_\_\_\_\_

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

Number/Street

Bldg./Apt. #

NJ

City/Town

State

Zip Code

**IF TUITION BILLS ARE TO BE SENT TO A DIFFERENT ADDRESS, PLEASE COMPLETE THE FOLLOWING:**

TUITION BILLS TO: \_\_\_\_\_

Name of Person

Number/Street

Bldg./Apt. #

City/Town

State

Zip Code

APPENDIX C  
INDIVIDUAL STUDENT REQUEST FORM

<b>INDIVIDUAL STUDENT REQUEST FOR LOAN OF TEXTBOOKS</b>	
Public School District Newark Public School	Nonpublic School Saint Vincent Academy
Address 2 Cedar Street Newark, NJ 07102	Address 228 West Market Street Newark, NJ 07103
Name of Student	Address
Grade	City, State, zip
Name of Parent	
<p>Under the provisions of N.J.S.A. 18A: 58-37.1 et seq., I hereby request under the     <u>Newark</u> (Public School District) to loan textbooks to the <u>Saint Vincent Academy</u> (Nonpublic School) in which my child is enrolled. I certify that my above name child and I are residents of the State of New Jersey. I understand that the public school district in which the nonpublic school is located has oversight of the State funds designated for providing the loan of textbooks to nonpublic school students pursuant to law and regulations.</p>	
<p>Signature of Parent/Guardian: _____</p> <p>Date: _____</p>	