

Has There Been An Educational Evaluation Of Your Child? _____

Does Your Child Receive Any Special Services AT School? _____

Speech Therapy _____
Social Worker / Guidance Counselor _____
Learning Disability Teacher _____
English As A Second Language _____
Other (Please Name It) _____

Does Your Child Receive Any Special Services Outside Of School? _____
If Yes, Please Name It _____

How Long Will Your Child Attend Saint Gabriel School?
Preschool Only _____
Preschool and Kindergarten Only _____
Through Grade 8 _____

Tuition Preference Order: Please Check The One That Applies

_____ November 1 Application Date: Siblings of children currently enrolled
Current Students (Including Preschool)
Children of Employees of St. Gabriel School and Parish

_____ December 1 Application Date: Parishioners and Children of Alumni

_____ January 1 Application Date: Catholic Non-parishioners and Non-Catholics

Applications will be accepted at any time, but will be considered according to the above preference dates. All completed applications will be considered for admission. All of the applicants in Grades K – 8 will be screened and evaluated. Applicants for Grades 1 – 8 will be required to spend a "shadow Day" in the grade they currently are enrolled in. Parents will be notified of the decision of the admissions committee no later than two weeks after the admission process has been completed. All acceptances are subject to a probation period. Please refer to the family handbook for further details regarding admission guidelines.

Applications will not be considered without the nonrefundable Application/Testing Fee. This fee applies to all new students and all Kindergarten students (even if they are enrolled in preschool). All other returning students are not required to pay another application fee. Admission for all students is not complete until receipt of the nonrefundable \$ 200.00 tuition deposit.

PARISH VERIFICATION FORM

Please check off the tuition plan that you are applying for.

Members of Saint Gabriel Parish should return this form to the school office. We will send all parishioner forms to the rectory at one time. **DO NOT BRING IT TO CHURCH OR THE RECTORY.**

Members of all other parishes should get the form signed by their pastor before submitting it to the office.

Family Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____

_____ We are registered at Saint Gabriel Parish (Plan A)
Envelope # _____

_____ We are registered at another Catholic Parish (Plan A).
Name of Parish: _____

_____ We are Catholic but are not affiliated with a
Parish. (Plan B)

_____ We are not Catholic. The church that we attend
is _____ (Plan B)

_____ We are not Catholic and are not affiliated with a church
(Plan B)

Signature of Parent / Guardian: _____

Date: _____

**I certify that the above named family is registered at my parish,
attends Mass consistently and regularly contributes to the parish.**

Name of Parish: _____

Signature of Pastor: _____

(or his designate)



State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 10th or 11th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Home Telephone Number	School	Grade		
Name of Parent/Guardian (Last, First, Middle)				
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*		

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

**Important: Complete Part I before your child is examined.
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY) |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

To the Health Care Provider: Please complete and sign.

_____ has had a complete history and physical exam on _____
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results			Immunization Record					
Note: * Mandated Screening/Test under Connecticut State Law			Vaccine (Month/Day/Year) Note: * Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.					
* Height:		BMI:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
* Weight:		* Postural:	DTP	*	*	*	*	
* Blood Pressure:		<input type="checkbox"/> Normal	DTP/Hib					
Pulse:		<input type="checkbox"/> Abnormal	DTaP					
* HCT/HGB:		Min. _____	DT/Td					
Urinalysis:		Slight _____	OPV	*	*	*		
* Gross dental:		Mod. _____	IPV	*	*	*		
Lead (Date/Result)		Marked _____	MMR					
			Measles	*	*		Booster for entry into K and 7th grade	
* Referral <input type="checkbox"/>			Mumps	*				
TB and Other Test Results (Sickle Cell, etc.)			Rubella	*				
TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No			HIB	*			Students under age 5	
Test	Date	Results	Hep B	*	*	*	Req. for entry into K and 7th grade.	
			Varicella	*			Students born 1/1/97 or later. Required for 7th grade entry.	
* Vision/ Type of Screening	* Auditory/ Type of Screening		PCV				Pneumococcal conjugate vaccine	
With glasses R L	Pass/Fail		Other Vaccines (Specify)					
20/ 20/	R							
Without glasses R L	L							
20/ 20/								
* Chronic Disease Assessment:			Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)					
Yes No			Exemption					
<input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe			Religious _____ Medical: Permanent _____ Temporary _____ Date _____					
<input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified			Recertify Date _____ Recertify Date _____ Recertify Date _____					
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II								
<input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex								
<input type="checkbox"/> Seizure Disorder								
<input type="checkbox"/> Other: Please specify _____								

This student has the following problems which may adversely affect his or her educational experience:

- Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior
- The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*
- The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

- This student may participate fully in the school program, including physical education activities.
- This student may participate in the school program and physical education with the following restriction/adaptation. *(Specify reason and restriction.)* _____

- Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
- I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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