St. Benedict the Moor School, Dayton, Ohio 45417
Returning Student Registration, School Year 2019-20

This registration form is for families and students currently attending St. Benedict the Moor Catholic School. We have a good school with excellent academic and spiritual programs. Please consider registering as soon as possible to insure your children's place for the 2019-20 school year.

1. Family Name _____
   Address_____
   City_____
   Daytime Phone_____ Evening Phone_____
   Email Address_____ (REQUIRED)

2. Please identify the public school district your child/ren would attend if they were not enrolling at St. Benedict. This information is **very important** as it assists us when clarifying transportation and other information.

   _____ _____
   School Building School District

3. Please list the names of all the students who will be re-enrolling. **Please do not include preschool children, new kindergarteners, or new students. Do include those already enrolled who will be returning next year.**

Name	**Current Grade**

4. **This registration must include a parent/guardian signature and a registration fee of 50.00 per student and $75.00 per family.**
5. Money orders, cash debit/credit cards.

6. I am in agreement with all of the above stated information and my registration fee is included.
7. I give permission for my son/daughter's picture or quotation to be used by this school and/or Archdiocese of Cincinnati in promotion of this school, the Archdiocese, and /or Catholic Education.

_____ _____
Signature Date

Thank you for making the decision to continue Catholic education at St. Benedict the Moor School.
Debra Johnson, Principal

Admissions Application
St. Benedict the Moor Catholic School
138 Gramont Avenue, Dayton, Ohio 45417
Phone: 937.268.6391 Fax: 937.268.9775
www.stbenedictdayton.org

Emergency Authorization (Updated Annually) Page 1 of 2

Last:	First:		Middle:
Gender: ☐ Male ☐ Female	Height:	Weight:	Birthdate:
Teacher:	Grade:	Home Phone:	
Address:			
Father's Name:		Work or Day Phone:	
Cell:		Email:	
Mother's Name:		Work or Day Phone:	
Cell:		EMAIL:	
Legal Guardian:		Student Lives With (include relationship):	

Instructions: Parent/Guardian to complete either **Part I** or **Part II** of this form and return to your child's school within 10 days after you receive it.

Purpose: To enable parent(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardian cannot be reached.

PART I or PART II MUST BE COMPLETED

PART I – Grant Consent

In the event that reasonable attempts to contact me (at the above numbers) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the following health care providers, or if the designated provider is not available, by another licensed health care provider or dentist; (2) the transfer of the child to any hospital reasonably accessible.

Health Care Provider/Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Preferred Local Hospital _____

This authorization does not cover major surgery unless the medical opinions of two other licensed physician or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history (include allergies, medications being take, and any physical impairments to which a health care provider should be alerted): _____

_____

_____

Date: _____ Parent Signature: _____

PART II – Refusal to Consent (DO NOT complete if you have completed Part I)

I do not give consent of emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that school authorities take no action or to: _____

_____

_____

Date: _____ Parent Signature: _____

(Turn over and complete other side)

Emergency Authorization Continued Page 2 of 2
Health Information (Updated annually)

Student's Name: _____ **Grade:** _____ **Rm.** _____

Additional emergency numbers if parents cannot be reached:

Name	Relationship	Home Phone	Work Phone	Cell Phone
1)				
2)				
3)				

Please complete the following health questionnaire regarding your child. The information will be reviewed by the school nurse and shared with school personnel as necessary (with permission – see below).

Does your child have any of the following (Please circle yes or no)?			**Comments**
Significant Health History	YES	NO	_____
Asthma	YES	NO	_____
ADD/ADHD (circle which)	YES	NO	_____
Seasonal Allergies	YES	NO	_____
Non – Life Threatening Allergies (food, insect,)	YES	NO	_____
Life Threatening Allergies (anaphylaxis)	YES	NO	_____
Bleeding Disorder	YES	NO	_____
Cancer	YES	NO	_____
Diabetes	YES	NO	_____
Eating disorder, anorexia, bulimia, obesity	YES	NO	_____
Hearing Concerns	YES	NO	_____
Heart (cardiac) condition	YES	NO	_____
Kidney/bladder condition	YES	NO	_____
Mental health concerns(depression, anxiety, fears etc.)	YES	NO	_____
Seizure Disorder	YES	NO	_____
Neurological condition (involuntary muscle movement, uncontrollable speech, etc.)	YES	NO	_____
Speech Delay	YES	NO	_____
Vision Concerns	YES	NO	_____
Other Chronic Health Concern not listed above	YES	NO	_____

Does your child require any of the following (Please circle yes or no)?			**Comments**
Glasses	YES	NO	_____
Contact Lenses	YES	NO	_____
Hearing aids	YES	NO	_____
Prosthesis	YES	NO	_____
Medication at school	YES	NO	_____
If yes, please list:			_____

Does your child require special health care needs? YES NO
If yes, the school nurse will contact you to develop a school based health plan.
If yes to any of the above, please explain: _____

_____

_____

Permission to share above Health Information with school personnel as needed? YES NO

Date: _____ Parent Signature: _____

(Turn over and complete other side)