

Saint Margaret Mary School

7318 North Oakley Avenue Chicago, Illinois 60645-1899
Phone 773-764-0641 Fax 773-764-1095 www.smmschool.com

Welcome to St. Margaret Mary School

At the time of registration we will need a copy of your child's Birth Certificate and if applicable Baptismal Certificate, as well as a copy of your child's last report card. The Registration Forms should be filled out completely and signed/dated.



All **NEW** students are required to provide the school proof of an eye examination by an optometrist or physician. These, along with medical and dental forms, are required by September 15, 2012. You are encouraged to contact your doctor's office as soon as possible so that your child can complete these required immunizations.

Beginning in the 2012 -2013 School Year, any child entering 6th grade must show proof of receiving one dose of Tdap (defined as tetanus, diphtheria, acellular pertussis) vaccine regardless of the interval since the last Dtap, DT or Td dose.

Students entering grades 7 and 8 who have not already received Tdap are required to receive 1 Tdap dose regardless of the interval since the last DTaP, Dt or Td dose.

Please note the following:

PreKindergarten Required Vaccinations

Complete Medical Exam
Eye Exam (new students)
Hepatitis B (3 shots)
Hib
Lead Screening
Dental Exam

Kindergarten Required Vaccinations

Complete Medical Exam
Hepatitis B(3 shots)
Lead Screening
Dental Exam
Eye Exam (new student)

Grade 2

Dental Exam

Grade 6

Complete Medical Exam
Dental Exam

Proof of Tdap vaccination

You are encouraged to contact your doctor's office as soon as possible so that your child can complete these required immunizations before September 15, 2012. If you need any further information, please contact the school office at 773-764-0641.

We wish you a peace-filled new year and look forward to working with you next school year. Until we meet again may God hold you in the palm of His Hand.

Peace,
Peggy Finnegan

ST. MARGARET MARY SCHOOL REGISTRATION FORM for SCHOOL YEAR 2012-2013

FOR OFFICE USE ONLY

Registration Fee: Paid / Date ____/____/____ M.O. # _____ Check # _____ Cash

STUDENT INFORMATION

Student's Legal Name _____ Male Female

Entering: Pre-Kindergarten (age 3 by Sept. 1, 2012) Kindergarten (age 5 by Sept. 1, 2012) Grade: _____

For Pre-Kindergarten, please check one: 5 full days 3 full days 5 half-days 3 half-days 2 half-days

Address _____ Apt. # _____ City _____ Zip code _____

Phone (____) _____ - _____ Birthplace _____ Birth date ____/____/____

Religion: _____

Ethnic Background: American Indian Asian Black/Non-Hispanic Hispanic White/Non-Hispanic Biracial

Name of Public School closest to your house: _____

Copy of Birth Certificate on file? Yes No Copy of Baptismal Certificate on file? Yes No

Medical Record on file? Yes No Dental Record on file? Yes No

Is Child a U.S. Citizen? Yes No If No, what country? _____

Does the child speak English? Yes No If NO, what language is spoken? _____

Do parents speak English? Yes No If NO, what language is spoken? _____

Name of other siblings at SMM: Name _____ Grade: ____; Name _____ Grade: ____

Name _____ Grade: ____; Name _____ Grade: ____

Name and birthday of siblings not yet in school: Name _____ Birth date: ____/____/____

Name _____ Birth date: ____/____/____

PARENTAL INFORMATION

Are you a Registered Parishioner in any Parish? Yes No. If yes, Name of Parish: _____

Father's Name: _____ Mother's Name: _____

Check here if Stepfather

Check here if Stepmother

Place of Birth: _____ Religion: _____ Place of Birth: _____ Religion: _____

Occupation: _____ Occupation: _____

Place of Employment: _____ Place of Employment: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

E-mail address: _____ E-mail address: _____

Check here if **SINGLE PARENT**. Child lives with: _____

SACRAMENTAL INFORMATION

Baptism: Date: ____/____/____ Church: _____ City: _____

Communion: Date: ____/____/____ Church: _____ City: _____

Confirmation: Date: ____/____/____ Church: _____ City: _____

EMERGENCY INFORMATION

Persons near school to be contacted if parent(s) cannot be reached. Please list their work phone if they are not home during the day. WE MUST HAVE THIS INFORMATION.

Name _____ Address _____ DAYTIME PHONE (____) _____

Name _____ Address _____ DAYTIME PHONE (____) _____

Family Doctor: _____ PHONE (____) _____

In the event of a serious emergency when I cannot be reached, I authorize St. Margaret Mary School to act in my behalf. I also agree that if any of the above information should change, I will notify the school immediately.

PARENT/GUARDIAN SIGNATURE

DATE

Registration Fee Is Non-Refundable

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Phone 773-764-0641 Fax 773-764-1095 www.smmschool.com

FINANCIAL REGULATIONS/CONTRACT

Please initial next to each statement to verify your understanding of the policy.



- _____ 1. For the purpose of school enrollment and tuition rates, parishioner is defined as follows: A parishioner is a Catholic person/family registered at St Margaret Mary Parish, contributing regularly to the support of the parish and participating in the life of the parish. Registered parishioners who do not participate in parish life and who do not contribute to the support of the parish will be changed to the non-parishioner status and tuition rate.
- _____ 2. The registration fee is non-refundable.
- _____ 3. Tuition payments may only be made through the FACTS Tuition Management . Each family must register with FACTS at the end of the previous school year.
- _____ 4. Each family must either raise a minimum of \$300 for the school through specified fundraisers or contribute \$300 to the school. In addition, each family must either volunteer for a minimum of ten (10) service (PACE) hours per year or make an additional \$300 contribution to the school. Fulfillment of these obligations is a requirement for each student's continued enrollment in SMM.
- _____ 5. At the reasonable discretion of the Principal, any family with a delinquent account will be informed in writing that, if payment is not received, their child/children will not be permitted to attend school.
- _____ 6. We assume your permission to publish your child's picture in our publications and advertising. We assume your permission to be included in the school directory. If you want to restrict this permission in any way, you must inform the Principal in WRITING prior to the beginning of the school year.

I have read the above financial regulations contract and I agree to the financial obligations of St Margaret Mary School as set forth herein and in the School Handbook.

Print Name of Parent/Guardian responsible for tuition payments

Signature of Parent/Guardian responsible for tuition payments

Date

2012 - 2013 St. Margaret Mary School Directory Permission Form

I give my permission for St. Margaret Mary School to publish our home phone number in the School Directory.

I do not give permission for St. Margaret Mary School to publish our home phone number in the School Directory.

Parent/Guardian's Signature

Directory Information

Please Print

Child/Children's Information

Last name (<i>List eldest first</i>)	First name	*Grade	*Homeroom
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian's Information

Father's Name: _____
Last First

Mother's Name: _____
Last First

Child's Home Address: _____
Street City Zip Code

Home Phone Number: _____

Work Number (*Optional*): _____

E-mail Address: _____

**Please note that we will put the grade and room in when these are assigned.*

St. Margaret Mary Internet Access Authorization

Each teacher and a parent or guardian must sign this authorization for each to student to receive Internet access at SMM. All Internet use must subscribe to SMM standards. Failure to subscribe will result in revocation of all privileges.

Terms and Conditions

1. Access to SMM's network should be for research or education. Teachers and administrators may monitor Internet use at any time.
2. Internet access is a privilege. The principal has the right to decide whether a student has abused this privilege and to revoke it.
3. Abuse includes but is not limited to:
 - Illegal copyright or contract violation
 - Commercial activities
 - Wasting resources, such as file space
 - Posting anonymous messages
 - Publishing offensive material
 - Unauthorized software downloading
 - Using copyrighted materials for commerce
 - Posting unauthorized materials
 - Advertising
4. Users must be polite, use appropriate language, protect the privacy of others, preserve smooth network operation, and treat all information on the network as private property.
5. SMM makes no warranties, expressed or implied for its Internet service. Each student is responsible for his or her own data, scheduling, deliveries, etc. Students use Internet information at their own risk. SMM does not guarantee the accuracy or quality of Internet information.
6. Parents and guardians agree to pay SMM in the extremely unlikely event of any losses, costs, or damages, including attorney fees, for any student violations of this agreement.
7. Students agree to alert the school of any security breach. Keep your user name and any password confidential. Do not use anyone else's account.
8. Harming anyone else's data may lead to cancellation of privileges.

All Internet use will be supervised. Classroom Internet use will be exclusively for research. Computer lab Internet use will be very limited and always for training in Internet skills.

Students: I agree to these limitations. I realize that failing to keep the agreement may lead to loss of privileges and/or other disciplinary action. I release SMM and her employees from any claims or damages. from Internet abuse.

Student Name

Student Signature

Date

Parents: i accept that SMM cannot entirely eliminate access to controversial or inappropriate material. I hold SMM and its employees blameless for any such exposure. I have discussed this agreement with my child/children and I request that he or they receive access.

Parent Name

Parent Signature

Date

Demurrer: I refuse to allow Internet access for my child/children. I realize that refusing to allow Internet access for my child may mean restricted access to the school's computers for computer education.

Parent Name

Parent Signature

Date

St. Margaret Mary 2012 - 2013 Gym Permission Form

Please check one:

I DO DO NOT give our permission for my child

Name: _____

Grade: _____

to participate in the Physical Education Program of St. Margaret Mary School with the understanding that St. Margaret Mary School, its faculty and instructors are not responsible for any accidents or injuries occurring during this program.

If you DO NOT give permission, a statement from the doctor is necessary for our files as Physical Education is a required class.

If you give permission, is there any health problem that the gym instructor should know about? If so, please explain:

Asthma: _____

Allergies: _____

Diabetes: _____

Heart Conditions: _____

Seizures: _____

Physical Handicap: _____

Blood Condition: _____

High Blood Pressure: _____

Kidney Conditions: _____

Rheumatic Conditions: _____

Previous Head Trauma: _____

Allergic Reactions: _____

Other: _____

Signed: _____

Parent/Guardian

Student's Name *(One form per student required)*

STUDENT REQUEST FOR THE LOAN OF TEXTBOOKS

"I hereby request the loan of secular textbooks in accordance with Section 18-17 of the School Codes of Illinois (Rev. Stat: 1989, Ch. 122, par. 18-17). I understand that this request will remain valid so long as my son/daughter is enrolled in St. Margaret Mary and that I may at anytime withdraw this request."
(School)

St. Margaret Mary in Chicago Cook
Name of School Town or City County

Signed: _____
Parent/Guardian

Date: _____

STUDENT REQUEST FOR MATHEMATICS & SCIENCE EQUIPMENT LOAN PROGRAM

"I hereby request the loan of mathematics and/or science equipment and instructional materials in accordance with Section 2-3/54 of the School Code. I understand that this request will remain valid so long as my son/daughter is enrolled in St. Margaret Mary and that I may at anytime withdraw this request."
(School)

St. Margaret Mary in Chicago Cook
Name of School Town or City County

Signed: _____
Parent/Guardian

Date: _____



State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011



Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian		Telephone # Home Work	
Street			City		Zip Code	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	DTP or DTaP																	
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title	Date
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3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
Date													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during night coughing?	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> •Bridge <input type="checkbox"/> •Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____	Parent/Guardian Signature _____ Date _____				
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes	No			
Bone/Joint problem/injury/scoliosis?	Yes	No			

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA
HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes No And any two of the following: **Family History** Yes No
Ethnic Minority Yes No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No **At Risk** Yes No

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** _____ (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** **Test performed**

Skin Test: **Date Read** / / **Result: Positive** **Negative** **mm** _____

Blood Test: **Date Reported** / / **Result: Positive** **Negative** **Value** _____

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Antagonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting **DIETARY** Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
 If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
 Yes No If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited

Print Name _____ (MD,DO, APN, PA) Signature _____ Date _____

Address _____ Phone _____

(Complete Both Sides)

DOCUMENTATION OF Tdap ADMINISTRATION

Student Name (Last, First Middle)		
DATE of Tdap ____/____/_____ MM DD YYYY	NAME OF PROVIDER WHERE Tdap ADMINISTERED	
DATE of BIRTH ____/____/_____ MM DD YYYY		
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.		
_____	_____	_____
Signature	Title	Date

Please Complete and Return to:

St. Margaret Mary School
Attn: Diane Herold
7318 N. Oakley Ave.
Chicago, IL 60645

Fax: 773-764-1095



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ (Month/Day/Year) Gender _____ Grade _____

Parent or Guardian _____ (Last) _____ (First)

Phone _____ (Area Code)

Address _____ (Number) _____ (Street) _____ (City) _____ (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: Normal or Positive for _____

Medical history: Normal or Positive for _____

Drug allergies: NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective lenses: No Yes, glasses or contacts should be worn for:
 Constant wear Near vision Far vision
 May be removed for physical education

2. Preferential seating recommended: No Yes

Comments _____

3. Recommend re-examination: 3 months 6 months 12 months
 Other _____

4. _____

5. _____

Print name _____

License Number _____

Optometrist or physician (such as an ophthalmologist)
 who provided the eye examination MD OD DO

Address _____

Phone _____

Signature _____

Date _____

Consent of Parent or Guardian
 I agree to release the above information on my child
 or ward to appropriate school or health authorities.

 (Parent or Guardian's Signature)

 (Date)

(Source: Amended at 32 Ill. Reg. _____, effective _____)