



Saint Katharine Drexel Catholic School

Embracing Leadership, Love, & Legacy

1053 Holland Road ∞ Holland, Pennsylvania 18966
215-357-4720 ∞ Fax 215-355-9526 ∞ www.skdschool.org

REGISTRATION INFORMATION

All registrations must be submitted with all of the items listed below. **NO REGISTRATION WILL BE ACCEPTED WITHOUT ALL THE NECESSARY PAPERWORK.** Your child will not be considered for acceptance until the **APPLICATION FOR ADMISSION** is complete (all Sacrament dates provided) and all required forms have been received.

- **A COPY OF YOUR CHILD'S STATE BIRTH CERTIFICATE**
First grade: child must be 6 years of age on or before August 31, 2016.
Kindergarten: child must be 5 years of age on or before August 31, 2016.
Preschool 4 years old: must be 4 years of age on or before August 31, 2016 and fully toilet trained
Pre-K 3 years old: must be 3 years of age on or before August 31, 2016 and fully toilet trained
- **AN ORIGINAL BAPTISMAL CERTIFICATE AT TIME OF REGISTRATION.**
- **ALL SACRAMENTAL INFORMATION**
Completed dates and names of churches for Reconciliation, Eucharist and Confirmation (copies of certificates - if applicable) must be provided.
- **REGISTRATION FEE**
A \$100 non-refundable registration fee per family is required.
- **CURRENT IMMUNIZATION RECORD SIGNED BY THE DOCTOR**
A copy of the immunization record **MUST** be included.
- **HEALTH HISTORY FORM**
A health history form completed by a parent must also be included with your immunization record. (The health history form will be included in the registration packet you receive at the time of registration).
- **IF DIVORCED OR SEPARATED**
A copy of the court order pertaining to custody (if applicable) or a note from a parent explaining custody arrangements must be provided.
- **TEST RESULTS**
Testing results for any student being registered (psychological, physical, educational, disability, etc.) must be provided.



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Dear Parents,

Thank you for considering registering your child(ren) in Saint Katharine Drexel Catholic School. As the Pastors who oversee this school, we are happy that you are considering a Catholic education for your child(ren). We truly believe that Saint Katharine Drexel School will provide your children with an outstanding education which will help them develop all of their God given talents, enabling them to be Catholic leaders for our families, our community, and our Church.

Tuition rates are the same for all registered parishioners of Saint Bede the Venerable, Assumption B.V.M., Saint Vincent DePaul, and Saint Cyril parishes who practice their faith by attending Sunday Mass and offer regular financial support to their parish.

It is our hope that no registered participating family, in the above mentioned category, who sincerely desires a Catholic education for their child at Saint Katharine Drexel School, will be denied registration because of true financial hardships. As in the past, each parish will address this concern on a case by case basis for their parishioners. Any additional financial aid scholarship, in addition to the parishes' subsidy, will be predetermined, and awarded by the parish, prior to the start of the academic year. Families who believe they are eligible and in need of this aid are asked to contact their local parish office and request a financial aid packet which will include the request for all pertinent financial information.

Tuition payments for the current academic year must be up to date according to the prior payment plan determined by each parish before registration can be accepted for the following academic year.

Once again, thank you for choosing Saint Katharine Drexel School and may God continue to bless you and your families.

Sincerely yours in Christ,

Monsignor Marine

Reverend Monsignor John C. Marine

Rev. Michael J. Davis

Reverend Michael Davis

The Mission of St. Katharine Drexel Regional Catholic School is to form Catholic leaders through academic excellence, personal discipline, and Christian service.



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Dear Prospective Family,

Thank you for your interest in registering your child(ren) at Saint Katharine Drexel Catholic School. SKD School is a place where each student receives the best education while living the gospel values each day. The administration, faculty, and staff are dedicated to providing each student with a quality Catholic education. We are committed to preparing our students for the 21st Century with a curriculum that is challenging and encourages our students to think critically while preparing them for real-world experiences. We encourage our students to demonstrate religious and moral values that will guide them as they mature into prayerful Christians.

We recognize parents as the first teachers of each child. We work in partnership with our families in the total development of their children to ensure that every child reaches his/her fullest potential and develops a love for learning. When working together, our students will in fact achieve greatness.

Enclosed please find our 2015-2016 Registration Packet. If you are interested in securing a space for your child(ren) for the 2015-2016 school year, please complete the forms enclosed and return them along with the required registration fee.

If you have any questions, please feel free to contact our Advancement Director, Ms. Lisa James. We look forward to welcoming you into our community.

God's blessings,

Ms. Clark
Principal

***Saint Katharine Drexel Catholic School forms Catholic leaders
through academic excellence, personal discipline, and Christian service.***



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Application for Admission GRADES Pre-Kindergarten - 8th grade

STUDENT INFORMATION

Name of Previous School _____

Name of Student _____
Last First Middle

Address _____

City _____ Zip _____

County of Residence _____ School District of Residence _____

Home Phone _____ E-mail Address: _____

Student Nationality and Race _____

City and State where student was born: _____

Date of Birth _____ Social Security# _____

Present Grade _____ Grade Applying For _____

With whom does the student reside: _____
Name (Please indicate Mother, Father or Guardian)

PARISH INFORMATION

Parish Name _____

Baptism Date ____/____/____ Name of Church _____

Address of Church _____
Address, City and Zip Code

Reconciliation Date ____/____/____ Name of Church _____

Address of Church _____
Address, City and Zip Code

Holy Eucharist Date ____/____/____ Name of Church _____

Address of Church _____

Please complete reverse side

Confirmation Date ____/____/____ Name of Church _____

Address of Church _____
Address, City and Zip Code

PARENT/GUARDIAN INFORMATION

Father

Mother (include maiden name)

Name _____

Address _____

City/State/ZIP _____

Religion _____

Country of Birth _____

Home Phone _____

Cell Phone _____

E-mail Address _____

Employer _____

Employer Phone _____

Marital Status Married Separated Divorced Widowed

Child lives with Both Mother Father Other/Guardian

*** If divorced or separated, please attach copy of court order. A court issued custody agreement must be on file in school office.**

EMERGENCY INFORMATION

Medical Allergies _____

Contact Person _____ Relationship _____

Phone # _____ Cell # _____

Doctor Name _____ Hospital of Choice _____

FORMS TO BE INCLUDED WITH APPLICATION

- Birth Certificate
- Baptismal Certificate
- Up-to-Date Immunization on Physician's Form
- Dentist Report
- CRSD Health History Form

Registration will not be complete without copies of ALL documents on file and \$100 non-refundable registration fee.



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CERTIFICATE OF INDIVIDUAL REQUEST FOR LOAN OF TEXTBOOKS AND INSTRUCTIONAL MATERIALS

Dear Parents,

State legislation authorizes the loan of textbooks and instructional materials by the Secretary of Education to children enrolled in Kindergarten through 12th grade in nonpublic schools. Our school is now in the process of requesting specific textbooks and materials to be loaned to your child(ren).

It is required however, that a parent of each child attending the nonpublic school individually requests a loan of textbooks and instructional materials. We are, therefore, enclosing the individual request form below.

Thank you for your continued assistance and cooperation.

Sincerely,

Ms. Clark
Principal

I hereby request the loan of textbooks and instructional materials in accordance with the Pennsylvania School Code of 1949 for my child(ren) attending SAINT KATHARINE DREXEL CATHOLIC SCHOOL.

Parent's Signature

Date



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REQUEST FOR STUDENT RECORDS

TO: _____
NAME OF PREVIOUS SCHOOL

RE: _____
STUDENT'S NAME

The above named student(s) is enrolled in our school. Please send all pertinent records to our office as soon as possible from their enrollment period in your school. These should include, but are not limited to:

- ✓ Administrative Records
- ✓ Attendance
- ✓ Standardized Test Scores
- ✓ Teacher Observations
- ✓ Evaluations
- ✓ Health Records
- ✓ Counselor Recommendations, etc.

Please mail to the above address as soon as possible to the attention of the school office.

Thank you in advance for your help.

Sincerely,

Laura A. Clark

Ms. Laura Clark
Principal

I have enrolled my child, _____, in the above school and hereby authorize you to release you to his/her school records.

Parent Signature: _____ Date: _____



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Parental Agreement for Admission Non-Catholic Students

It is our (my) wish that our (my) child(ren) attend Saint Katharine Drexel Catholic School. I (We) understand that our (my) child(ren) is (are) obligated to attend classes, study and actively participate in Religion class and to fulfill the requirements for this subject and, also, to attend all religious functions offered as part of the school program. I (we) agree that I will not request that my child(ren) be removed from Religion class or liturgical functions nor will I (we) remove them from these functions.

I (we) also agree to assume the obligation to pay the specified tuition and school fees and agree to support the philosophy, goals, objectives and regulations of the school.

I understand and agree that failure to comply with the terms of this agreement and its tenets, may result in a request to withdraw my child(ren) from the school.

Principal

Date

Parent Signature

Date

Parent Signature

Date

Are Your Kids Ready for School?

Getting kids ready to go back to school can be a frantic time. Make it easier on yourself this year, by scheduling an appointment early for your kids to get the immunizations that are required for school in Pennsylvania.



Immunizations Required for Children Entering ALL Grades

Number of Doses	Vaccine
1 2 3 4	Tetanus* (1 dose on or after the 4 th birthday)
1 2 3 4	Diphtheria* (1 dose on or after the 4 th birthday)
1 2 3	Polio
1 2 3	Hepatitis B
1 2	Measles**
1 2	Mumps**
1 2	Varicella (Chickenpox) Vaccine or history of disease
1	Rubella** (German Measles)

* Usually given as DTaP, DT, or Td
 ** Given as MMR (Measles, Mumps, and Rubella)

Additional Immunizations Required for 7th Grade Students

1	Tetanus, Diphtheria, Pertussis (Tdap)
1	Meningococcal Vaccine (MCV)

Learn about other immunizations that are recommended for your child at: www.cdc.gov/vaccines/recs/schedules/default.htm.
 These immunization requirements apply to children attending ALL Pennsylvania schools.
 Children not up to date with all the required immunizations may be removed from school during a disease outbreak.
 Pennsylvania's school immunization requirements can be found in 28 PA CODE CH. 23 (School Immunizations).

Contact your health care provider, school, or local health department for more information.



www.immunizepa.org

**Council Rock School District
Bucks County Pennsylvania**

**PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE _____ 20____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____ DATE OF BIRTH _____ SEX _____
M F

ADDRESS _____
Last First Middle

No. and Street City or Post Office Borough or Township County State Zip Code

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter month, day & year each immunization was given			BOOSTERS & DATES		
	DOSES					
Diphtheria and Tetanus (circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /	Tdap 7 th gr 2011-12 (new requirement) / /
Polio (circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /	
MMR 1 st dose after 1 yr of age	1 / /	2 / /				
Measles 1 st dose after 1 yr of age	1 / /	2 / /				
Mumps 1 st dose after 1 yr of age	1 / /	2 / /	(new requirement 2011)			
Rubella after 1 yr of age	1 / /					
Hepatitis B	1 / /		2 / /		3 / /	
Hepatitis A	1 / /		2 / /		3 / /	
HIB	1 / /		2 / /		3 / /	
Varicella	1 / /		2 / / (2011-2012 new requirement)			Varicella Disease or Lab Evidence Date: _____
Entering 7 th grade 2011-12 Meningococcal Conjugate (MCV)			1 / / (2011-2012 new requirement)			
Other	1 / /		2 / /		3 / /	

- MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health.
- RELIGIOUS EXEMPTION A strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent or guardian.

If Applicable:

Tuberculin Tests	Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)			Signature		

Follow-Up of significant tuberculin tests:
 Parent/Guardian notified of significant findings on _____ (Date)
 Result of Diagnostic Studies: _____ (Date)
 Preventive Anti-Tuberculosis – Chemotherapy ordered: NO YES _____ (Date)

Significant Medical Conditions (√)

	Yes	No	If Yes, Explain
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (√)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ()				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

Print Name of Examiner

Address

Telephone Number

COUNCIL ROCK SCHOOL DISTRICT

FAMILY HEALTH HISTORY

Child's Name _____ M F Birth Date _____
 Address _____
 Telephone _____ Birth Place _____
 Father's Name _____ Mother's Name _____
 Family Doctor _____ Telephone _____
 Name of Pre-School Program _____

CHILD'S HISTORY

Does your child have:	Yes	No	Has your child had:	Yes	Date (yr)
Allergies	___	___	Chickenpox	___	_____
If yes, explain _____			Head Injury/Concussion	___	_____
Asthma	___	___	Febrile Convulsions	___	_____
Ear Infections	___	___	Hepatitis	___	_____
Convulsions	___	___	Measles, German	___	_____
Frequent Colds	___	___	Measles, Regular	___	_____
Frequent Sore Throats	___	___	Mononucleosis	___	_____
Speech Difficulties	___	___	Mumps	___	_____
Vision Problems	___	___	Polio	___	_____
Other Concerns	___	___	Rheumatic Fever	___	_____
Is your child on any medications	___	___	Scarlet Fever	___	_____
List medications _____			Whooping Cough	___	_____
			Other	___	_____

If your child has a history of **Head Injury/Concussion** – Please explain: _____

Did mother have measles or other serious illness during pregnancy? _____

Was oxygen administered to your child at birth? _____

Any serious illnesses or surgery? _____ If yes, what? _____

Is your child under medical treatment? _____ If yes, explain _____

State any other information which would aid the school in a better understanding of your child.

Family History

Is there a history of:	Yes	Relationship
Allergies	___	_____
Asthma	___	_____
Color Deficiency (Blindness)	___	_____
Convulsive Disorders	___	_____
Diabetes	___	_____
Hearing Disorders	___	_____
Reading Disorders	___	_____
Tuberculosis	___	_____
Visual Disorder	___	_____
Other	___	_____

Child's Developmental History

Birth Weight _____
 Age Walked _____
 Age Talked _____
 Age Toilet Trained _____
 Age Stopped Bed-Wetting _____

_____ Date

_____ Signature of Parent/Guardian

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 20__

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
_____ Last	_____ First	_____ Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	T	S	R	Q	P	O	N	M	L	K				Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address

KATHERINE DREXEL REGIONAL CATHOLIC SCHOOL

COUNCIL ROCK SCHOOL DISTRICT
Bucks County, Pennsylvania

Dear Parent or Guardian,

** Form for Prescription Meds only **

Prescribed medications which are necessary for the health of a child may be administered during the school day. It is recommended that, whenever possible, all medications be administered at home by the parent or guardian. The first dose of any new medication should always be administered at home to ensure close observation of any adverse reaction. If your physician decides it is necessary for your child to receive a medication during school hours, the parent or guardian may request that the school nurse administer the physician prescribed medication at scheduled times. The following school district policies apply to all medications brought to school:

- The "Permission to Administer Medications in School" form below must be completed and signed by the physician and the parent or guardian for all medications - both prescribed and over-the-counter.
- Medication must be sent to school in the original pharmacy container with the current prescription label. Upon request, pharmacies can prepare a duplicate container to be used for school.
- All medications must be brought directly to the health office by the parent, guardian, or a responsible adult designated in writing by the parent or guardian.
- Students who have medications of any kind in their possession (in lunch boxes, school bags, etc.) may be considered in violation of the school district drug and alcohol policies and may be subject to disciplinary action.
- A licensed registered nurse employed by the school district shall be the only district employee responsible for the administration of medications.
- If a licensed registered nurse is unavailable to administer the medication on a time schedule determined by the student's physician, the school nurse and parent or guardian will develop a care plan to ensure that the dosage is administered as scheduled.
- All medications are kept in the health office in a locked cabinet.
- Acetaminophen, for which the district has a standing order from the district physician, will be administered as needed to all students with the signed permission of parent or guardian as noted on the student's emergency information form.
- Ibuprofen, for which the district has a standing order from the district physician, will be administered as needed to students in grades 7-12 with the signed permission of parent or guardian as noted on the student's emergency information form.

Please take this form to your physician and have the instructions recorded below regarding the administration of your child's medication.

Permission to Administer Medications in School

Date medication to start _____ Date to discontinue _____

Name of student _____ Grade/teacher _____

Diagnosis _____

Name of medication _____ Strength _____ Dosage _____

Frequency of administration _____ Recommended time of administration _____

Special instructions/effects to observe _____

Other medications this child is presently taking _____

Signature of physician _____

Telephone number of physician _____

I hereby give permission for the school nurse to administer this medication to my child during the school day.

Date _____

Signature of parent or guardian _____