Immaculate Conception Academy

NEW STUDENT
INFORMATION FORM

Date of Application ________________

Student's Name ____
Last **First** **Middle**

Home Address
____

City ____________________ State __________ Zip ________ Phone ______________

Age ____ Birth Date _______ Sex ____ Birthplace _____________________________

List the following if the child is Roman Catholic:

Sacrament	Date	Church	Location
Baptism	______________	________________	_________________
Penance	______________	________________	_________________
Holy Communion	______________	________________	_________________
Confirmation	______________	________________	_________________

SCHOOLS PREVIOUSLY ATTENDED:

Grade	Dates Attended	Name and Location of School

School District where student resides ____

The student has changed schools _____ times. At what grade level(s)?

Has the student ever been _____ dismissed suspended from any school?
_____ denied admission to any school?
_____ requested to not return to any school?

so, please give details:

Has the student had any scholastic difficulties? If so, explain:

Has the student ever used, or does he/she now use tobacco, drugs or alcohol?

If so, explain. (Use of these in any function related to the school is grounds for immediate expulsion, at the discretion of the principal.)

Does the student:

Attend Sunday Mass?	Always _____	Sometimes _____	Never _____
Participate in school activities?	Always _____	Sometimes _____	Never _____
Spend time in watching television?	Always _____	Sometimes _____	Never _____
Do school assignments at home daily?	Always _____	Sometimes _____	Never _____
Work for others, i.e. babysitting?	Always _____	Sometimes _____	Never _____

Are there any unusual factors in the student's life, e.g., absence of father or mother, serious or chronic illness of either parent, adoption, etc.?

Please comment:

Please give any other information regarding this student which you consider to be helpful to the faculty and/or the administration of Immaculate Conception Academy.

Immaculate Conception Academy

MEDICAL EXAMINATION
(To Be Completed By Physician)

Name: ____ **Grade:** __________

Date of Birth: _________________ **Social Security Number:** __________________

HEALTH HISTORY

Anemia	____	**Heart Disease**	____	**Rheumatic Fever**	____	**Allergies**	____
Chicken Pox	____	**Measles**	____	**Scarlet Fever**	____	**Ear Conditions**	____
Diabetes	____	**Mumps**	____	**Tuberculosis**	____	**Freq. Cold**	____
Sore Throat	____	**Epilepsy**	____	**Nephritis**	____	**Contact with TBC**	____
Asthma	____	**German Measles**	____	**Pneumonia**	____	**Operations**	____

Serious Injuries ____

Height ______________________	**Teeth** ______________________	**Skin (Non-Comm.)** ___________________
Weight ______________________	**Heart** ______________________	**Convulsive Disorder** __________________
Ear (Otoscopic)________________	**Lungs** ______________________	**Nervous System** ______________________
Lymph Nodes _________________	**Hernia**______________________	**Speech**_______________________________
Thyroid ______________________	**Genito-Urinary** ______________	**Nutrition** ____________________________
Nose_________________________	**Orthopedic**___________________	**Other**________________________________
Scoliosis______________________	**VISION: Rt. Eye**________ **Lt. Eye** ________	

Does the student exhibit any difficulty in the interpretation of visual, auditory, or tactile stimulia?

____

May this student participate in Physical Education? ____

Within the previous year, has this student had any:

1. **Operation (specify)?**____
2. **Special Medications or Treatments? (e.g. insulin, tranquilizers)**
   ____
   ____

Comments:
____
____
____
____

Physician's Signature____ **Date:** ________________

THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL OFFICE BY THE FIRST DAY OF SCHOOL

CERTIFICATE OF IMMUNIZATION

This is to certify that ________________________ ________________________________
(first name) **(last name)**

________________ ______________________ ______________________________________
(grade) **(age)** **(date of birth)**

received the following immunizations:

	Date of 1st Immunization (Month, Day, Year)	**Date of 2nd Immunization** (Month, Day, Year)
*MMR (After one year of age) Measles, Mumps, Rubella	___________________	__________________
*HIB vaccine (Haemophilus Influenza Type B - Between 18 months and 5 years of age)	___________________	___________________
Hepatitis (Optional)	___________________	___________________
Varicella (or history of disease)	___________________	___________________

	Dates	**Date of Boosters**
Oral Polio Sabin (TOPV -	#1____________________	#1_____________________
4 unless 3rd was after 4th	#2____________________	#2______________________
birthday)	#3____________________	#3______________________
	#4____________________	#4______________________
Diptheria - DPT, DT or TD		
	#1____________________	#1______________________
(At least three doses)	#2____________________	#2______________________
	#3____________________	#3______________________

*Full doses only

** Tdap booster is now recommended to children starting at age 11-12 years. This replaces the previous use of Td. Also recommended for that age is the Meningococcal Conjugate Vaccine (Menactra). This vaccine was more widely given in the past to kids entering college.

Religious or Medical Exemption (Attached)

____ ________________________
Physician's Signature **Date**

Physician's Stamp: