Saint Raphael School

Student Application

Date of Application____/____/_____ Entering Grade_____

Student Information:

Student Name_____ Gender_____
First Middle Last

Date of Birth___/___/____Place of Birth_____ US Citizen: ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ Amer. Indian ☐ Asian ☐ Pacific Islander

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language Spoken:_____

Admitted from_____ Location_____ Grade_____
School

Religious Affiliation: ☐ Catholic ☐ Non-Catholic Church_____

Sacrament	Parish	Location	Date
Baptism			
Penance			
First Communion			
Confirmation			

Person Responsible for Financial Obligations (if not parent/guardian named above):

Name_____ Phone_____

Address_____

Other Information:

Has the student been classified as having a learning disability? ☐ Yes ☐ No

If yes, please state the disability_____

Has the student received Compensatory Education? ☐ Yes ☐ No

Medical Information:

Does the student have any physical disabilities which require special attention? ☐ Yes ☐ No

If yes, please state the disability_____

Family Physician_____ Phone_____

Please complete this form and return with the Registration Packet along with the non-refundable registration fee of $150.00.

Saint Raphael School does not discriminate on the basis of race, color, sex, nation or ethnic origin in the acceptance of students.

For Office Use Only:

Application Fee_____ Cash or Check#_____Initials_____

1/26/2022 JP

Saint Raphael School

151 Gropp Avenue Hamilton, NJ 08610
Phone: 609-585-7733 Fax: 609-581-8436
www.srsnj.org

Inspired by Faith Empowered by Knowledge United by Community

Request For Student Records

To: _____
_____
_____

Date: _____

Student Name: _____

Current Grade: _____ Date of Birth: _____

The student listed above has been accepted for entrance to Saint Raphael School. Please forward the following documentation to complete this student's file:

- All Health and Academic Records
- Child Study Team Reports/Individual Service Plans
- Confidential Materials to Support Learning
- Other-Additional Information Which May Be Pertinent

Please contact the Main Office if you have any questions regarding the requested information (609) 585-7733.

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal Signature Date

New Jersey Department of Education
Office of School Finance

(B6T) Nonpublic School Transportation Application (N.J.A.C 6A:27-2.5)

Instructions

It is the obligation of the parent or guardian of nonpublic school students to annually obtain the Nonpublic School Transportation Application from the administrative office of the nonpublic school for each student for which transportation services are being requested. Submit a separate application for each student.

Note:

- If there is a change of home address, a new application shall be submitted to the public school district of residence.
- If there is a change in the nonpublic school of attendance, a new application shall be submitted to the public school district of residence.
- Complete this application and return it to the nonpublic school on or before March 10th preceding the school year in which transportation is being requested.
- Late applications — Any application received after March 10th will be a late application and must be accompanied by a statement of the reason for lateness. Eligible students will receive transportation or aid in lieu of transportation based on the date the application is received by the public school.
- It is the obligation of the nonpublic school administrator to annually collect the application and submit it to the public school district from which transportation is being requested prior to March 15th.
- It is the obligation of the public school administrator to notify the parent or guardian as the determination of each application by August 1st.
- A district board of education shall pay aid in lieu of transportation to the parent or guardian of an eligible student only after receiving a signed "Nonpublic School Transportation Payment" voucher (B7T) as prescribed by the Commissioner of Education.

Application Form

School Year: 2024-2025 Resident District Board of Education: _____

Student Name: _____
Last First Middle

Date of Birth (mm/dd/yy): _____ Parent/Guardian Name: _____

Daytime Phone: _____ Email Address: _____
Area code + number

Home Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Full name of school to be attended: Saint Raphael School

Phone: 609-585-7733 Address of School: 151 Gropp Avenue, Hamilton, NJ 08610
Area code + number

Student's grade for the coming year:

Shortest one-way mileage between home and school

(shortest route along public roadways or walkways to the nearest tenth of a mile)

Date school opens (mm/dd/yy): Sept 2024 Date school closes (mm/dd/yy): June 2025

School hours: 7:45 AM to 3:00 PM

Name of school of attendance in prior year:

Address:

Signature: Date (mm/dd/yy):

Public School Use Only (Do *not* write below this line)

Your application has been reviewed by the resident district board of education. The following determination has been made:

☐ Transportation will be provided

☐ You are eligible for payment in lieu of transportation

☐ Ineligible

Reason:

Title:

Signature: Date (mm/dd/yy):

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

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Educational Services Commission of New Jersey

Existing legislation provides certain nursing services and funding for full-time students in private schools. Included in these services, based on available state aid, is maintenance of student health records, hearing assessment and scoliosis screening. In addition, your child will receive emergency nursing services for any school-related illness or injury. Please sign the form below and return it to the SRSNJ nurse's office as soon as possible.

☐ I DO give my permission

☐ I DO NOT give my permission

For my child _____ in grade _____ to participate in nursing services. I give the Saint Raphael School nurse permission to share medical information with staff involved in my child's care.

_____

Signature of Parent/Guardian Date

Medical Update for the 2024-2025 School Year

Have there been any changes in your child's medical status since last year? _____
If yes, please describe: _____
_____
_____

Please list anything (foods, pollen, insects, medications, etc) your child is allergic to: _____
_____
_____

Illness/Accidents/Hospitalizations: _____
_____
_____

Any international travel during the summer? _____
Country: _____ Dates of Visit: _____

Please provide documentation of any recent immunizations, signed by a doctor, if the school does not already have a record.

Please be advised that if your child requires medication during school hours, the required forms must be completed by the doctor and parent, and returned to school. This includes over the counter medication. If your child needs to be excused from Physical Education classes, a note from the doctor indicating the reason and period of exclusion, is required.

We look forward to a healthy school year. Please feel free to contact the SRSNJ Nurse's Office at any time at 609-585-4925.