

LEARNING SUPPORT/ SCHOLARS

REGISTRATION INFORMATION

STUDENT'S NAME: _____

SCHOOL: _____ GRADE: _____

PLEASE CHECK PROGRAM

LEARNING SUPPORT SCHOLARS

CENTER FOR INCLUSIVE EDUCATION SITE:

St. Benedict School

ATTENDED CLASSES AT CENTER PREVIOUSLY YES NO

1ST COURSE NAME: _____

SESSION: _____

2ND COURSE NAME: _____

SESSION: _____

3RD COURSE NAME: _____

SESSION: _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

*****ALL CHECKS SHOULD BE MADE PAYABLE TO ST. BENEDICT SCHOOL. FULL PAYMENT MUST ACCOMPANY THE REGISTRATION FORM. *****

PLEASE MAIL REGISTRATION TO
ST. BENEDICT SCHOOL
CENTER FOR INCLUSIVE EDUCATION
2324 NEW STREET.
BLUE ISLAND, IL 60406

PLEASE SEE REVERSE SIDE FOR EXCHANGE OF INFORMATION

ARCHDIOCESE OF CHICAGO

Office of Catholic Schools



Post Office Box 1979
Chicago, Illinois 60690-1979

TEL (312) 534-5200
FAX (312) 534-5295

CONSENT FOR THE EXCHANGE OF INFORMATION

STUDENT INFORMATION

Name _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____

Parent Name(s) _____ / _____

Home Phone _____ Work _____

Cell Phone _____ Email Address _____

Emergency Contact - Name _____ Relationship _____
(other than parent)

Phone _____ Cell Phone _____

School Attending _____ Grade _____ Room _____

Current Teacher(s) _____

CONSENT FOR EXCHANGE OF INFORMATION

I do hereby give permission for a mutual exchange of information concerning my child, between the Archdiocesan Center for Inclusive Education and the school listed above. I understand that the exchange of information will continue throughout the course of the program.

Parent Signature _____ Date _____

I give permission for the school to provide a copy of my child's most current standardized test scores and the most current report card to the Archdiocesan Center for Inclusive Education. (Not required for counseling services.)

Parent Signature _____ Date _____

PLEASE SEE REVERSE SIDE FOR REGISTRATION

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT**

SCHOOL _____

SCHOOL YEAR _____

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian _____ Parent/Guardian _____

Home Phone () _____ Work () _____ Home Phone () _____ Work () _____
Cell Phone () _____ Cell Phone () _____

Name of Student's Physician _____ Phone () _____

Address _____ City _____ State _____

Medical Insurance Provider _____ Policy/Insurance # _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME _____ RELATIONSHIP TO STUDENT _____
Phone 1 () _____ Phone 2 () _____

NAME _____ RELATIONSHIP TO STUDENT _____
Phone 1 () _____ Phone 2 () _____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.

PHOTO/ACADEMIC WORK PERMISSION FORM

On occasion, _____ (school) uses photos and/or academic work of students in school/parish publications to share information about the school. School publications include, but are not limited to: the website, school yearbook, student academic work, advertisements, annual reports, posters, newsletters, parish bulletins and other public relations material.

In addition, local news organizations may hear of our activities or events, and our school may invite or allow them to photograph or record our events.

Please check and sign below:

_____ My child's photo or academic work may be published in any format including group or individual photos.

_____ My child's photo or academic work may **not** be published in any format including group or individual photos.

PLEASE PRINT:

Name of Student _____ Grade _____

Name of Student _____ Grade _____

Name of Student _____ Grade _____

Name of Student _____ Grade _____

Name of Parent/Guardian _____

_____ Date _____

Parent/Guardian Signature

This form will remain in effect until the parent/guardian requests a change in writing.

If you do not return this form by _____ (date), it will be assumed that you give permission for your child's photo or academic work to be included in any form of communication.