



Dear Prospective Holy Name of Jesus School Family:

Thank you for your interest in enrolling your child(ren) at Holy Name of Jesus School. Registration for the 2021/2022 school year is online through a program linked to our school database system, Rediker Software.

The registration application can be accessed via the Holy Name of Jesus School website www.holynameofjesus.com where there will be a link to Admissions (Apply Now).

You will be redirected to the Rediker secure website to create an account, and then access our student application. Please follow all directions on how to complete the needed information. After completing the application, please be sure to review it for completion before submitting. Once you Submit the information you will not be able to return to the registration forms.

Please contact our office with any technical problems and we will be able to assist you.

Thank you for your patience during the registration process.

Sincerely,

A handwritten signature in cursive script that reads 'Sister Rita'.

Sister Rita Smith, SSJ
Principal



Dear Parent/Guardian,

The information contained on the registration form is correct. This enrollment is subject to the receipt and verification of all previous educational records.

The parents and/or Guardians of the applicant student hereby agree that they and their applicant student will abide by each of the policies and procedures that may be adopted from time to time by the Diocese of Harrisburg and by the Holy Name of Jesus Parish/School, including but not limited to those set forth or referred to in the Holy Name of Jesus School Parent/Student Handbook and the Diocese of Harrisburg School Policies and Regulations manual.

Date: _____

Parent Signature _____



Holy Name of Jesus School
6190 Allentown Boulevard
Harrisburg, Pennsylvania 17112
717-657-1704

School Year 2021-2022

Dear Parent:

As part of our registration process at Holy Name of Jesus School, we ask all families for a \$100.00 non-refundable registration fee. This fee is due by April 1, 2021 after this date the fee will increase to \$125.00. Please complete the information below for your family by listing those children you wish to enroll for the 2021-2022 school year and include those presently enrolled and the grade level they will be entering.

Blessings,

Sister Rita Smith, SSJ
Principal

REGISTRATION

We have received the family registration fee of \$100.00 from the

_____ (Family Name)

Child(ren)s Name(s)

Grade Level



DIOCESE OF HARRISBURG – SECRETARIAT FOR EDUCATION

4800 Union Deposit Road • Harrisburg • Pennsylvania 17111-3710
(717) 657-4804 • FAX (717) 657-3790 • www.hbgdiocese.org

**CATHOLIC SCHOOL PARENTS
MEMORANDUM OF UNDERSTANDING**

As a parent/guardian of a student in a Catholic School I understand and affirm the following:

1. The primary purpose of a Catholic school education is to form students in the values of Jesus Christ and the teaching of the Catholic Church.
2. Catholic schools are distinctive religious education institutions operated as programs of the Catholic Church; they are not private schools but are administered and supported by the sponsoring parish(es), and the diocese.
3. Attending a Catholic school is a privilege, not a right.
4. While academic excellence and involvement in extracurricular activity (i.e., sports, clubs, etc.) are important, fidelity to the Catholic identity of the school is the fundamental priority.
5. The school and its administration have the responsibility to ensure that Catholic values and moral integrity permeate every facet of the school's life and activity.
6. In all questions involving faith, morals, faith teaching, and Church law, the final determination rests with the diocesan bishop.

As a parent/guardian desiring to enroll my child in a Catholic school, I accept this memorandum of understanding. I pledge support for the Catholic identity and mission of this school and by enrolling my child I commit myself to uphold all the principles and policies that govern a Catholic school.

Father: _____
Printed

Mother: _____
Printed

Signature

Signature

(Guardian): _____
Printed

Signature

Student's Name _____

School: _____

Date: _____

SECRETARY OF EDUCATION

COMMONWEALTH OF PENNSYLVANIA

CERTIFICATE OF INDIVIDUAL REQUEST

FOR LOAN OF

TEXTBOOKS/INSTRUCTIONAL MATERIALS

I hereby request the loan of textbooks/instructional materials in accordance with Pennsylvania Act 195/Act 90 for my children attending **Holy Name of Jesus School, Harrisburg, PA.**

Child(ren): _____
(please print)

Date

Parent Signature

N.B. Act 195/Act90 applies to Pennsylvania residents attending school in Pennsylvania only.

Holy Name of Jesus School

6190 Allentown Blvd.

Harrisburg, PA 17112

717-657-1704

Registration Tuition Agreement 2021/2022

Registration Fee of \$100/family- Due April 1, 2021.

Student's Name (please print)	Grade (2021-2022)

Please check the appropriate box that best describes your financial position.	Grades K thru 8	1 Child	2 Children	3 Children	4 Children or more
	Active Catholic Parishioner	\$3,990	\$6,200	\$7500	Add \$1000 for each additional child
	Non-Catholic Tuition (per child)	\$5,600			

Financial Aid Information:

If you are interested in applying for Financial Aid, please go to www.holynameofjesus.com for information and a link to the on-line application.

My financial commitment for my child(ren)'s Catholic education for the 2021-2022 school year is

\$ _____. I understand that this amount may be paid monthly for a 12-month period beginning July 2021.

Date

Parent/Guardian Signature

Please complete this form, then pay the \$100.00 registration fee at the school office.



Holy Name of Jesus School

PARENTAL PERMISSION FOR RELEASE OF STUDENT RECORD

I herewith give my permission to _____ for
the release of the information requested for my (son/daughter).

Student's Name (please print)

Grade

Parent/Guardian Signature

Date

REQUEST FOR TRANSCRIPT OF STUDENT RECORD

Date

Student's Name _____ has been admitted

to the _____ of **Holy Name of Jesus School, 6190 Allentown Blvd., Harrisburg, PA 17112.**
Grade

- Please Forward:**
- Health and Dental Records
 - Personal Health History
 - Transcript of Records
 - Discipline Records
 - Individualized Education Program (IEP)

Principal



CENTRAL DAUPHIN SCHOOL DISTRICT
600 RUTHERFORD ROAD
HARRISBURG, PA 17109

PHYSICAL AND DENTAL EXAMS

Pennsylvania School Health Law requires all children to have a physical and dental exam upon entry to school. Physical exams are also required in grades 6 and 11, dental exams are required in grades 3 and 7. These exams may be done by the school physician/dentist or your family physician/dentist. These exams may be obtained within twelve months prior to the required school year.

Please indicate your preference below.

- _____ I plan to have the exams completed by my family physician/dentist. I understand if these exams are not submitted by September 30, the exams will be done by the school physician and school dentist.
- _____ I plan to have the physical exam completed privately by September 30, but would like the school to do the dental exam. I understand if these exams are not submitted by September 30, the exams will be done by the school physician and school dentist.
- _____ I plan to have the dental exam completed privately by September 30, but would like the school to do the physical exam. I understand if these exams are not submitted by September 30, the exams will be done by the school physician and school dentist.
- _____ I give permission for the school doctor and school dentist to do the exams.

Student's Name *(please print)*

Parent/Guardian's Signature

Date

School Health Services
DPS-100D (Rev.5/04)

NURSING SERVICES OF CENTRAL DAUPHIN SCHOOL DISTRICT
HOLY NAME OF JESUS SCHOOL

Dear Parent:

The **Pennsylvania School Health Law requires** all children entering school for the first time to have:

1. WRITTEN Proof of the following immunizations from your PHYSICIAN:

(1) *Diphtheria and Tetanus*: Four or more properly-spaced doses which may be administered as a single antigen vaccine or in a combination form (Dtap). The fourth dose shall be administered on or after the 4th birthday.

(2) *Poliomyelitis*: Four or more properly spaced doses polio vaccine, which may be administered as a single antigen vaccine, or in a combination form (Dtap). The fourth dose shall be administered on or after the 4th birthday and at least 6 months after previous dose.

(3) *Measles (rubeola), Mumps, and Rubella (German measles)*:. Two properly-spaced doses of measles and mumps vaccine and one dose of rubella vaccine administered at 12 months of age or older, or a history of immunity proved by laboratory testing. Each dose of measles, mumps, or rubella vaccine may be administered as a single antigen vaccine or in a combination form (MMR).

(4) *Hepatitis B*. Three properly-spaced doses of hepatitis B vaccine, with the third dose given at or after the age of 6 months.

(5) *Chickenpox (varicella)*. Two properly-spaced doses administered at 12 months of age or older or *Evidence of immunity* by Laboratory evidence or a written statement of a history of chickenpox disease from a parent, guardian or physician.

The immunizations are required as a condition of admission to school. Therefore, written proof from a physician or medical clinic of the necessary immunization must be presented to the office to complete the registration. All doses of immunizations MUST be completed by the fifth day of school to prevent exclusion. A child shall be exempt from the requirements for immunizations whose parent or guardian object in writing to such immunizations for religious grounds, or whose physician certifies that the child's physical condition or recent immunization administration contraindicates immunization.

2. A medical examination completed no earlier than within 12 months prior to school entry

3. A dental examination completed no earlier than within 12 months prior to school entry

The medical examination and dental examination can be verified on the attached forms. If the completed forms are not received by the 4th week of school, these examinations will be scheduled at school. Your cooperation in carrying out these phases of the health program will be appreciated. Please feel free to contact your school nurse at any time.

Sincerely,

School Health Services

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**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 <input type="checkbox"/> M <input type="checkbox"/> F
Last _____ First _____ Middle _____		

ADDRESS _____

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

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, And Year Each Immunization Was Given				
	DOSES				
	BOOSTERS & DATES				
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other _____					

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

(Continued on Back)

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

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 or Township	County	State	Zip
----------------	---------------------	---------------------	--------	-------	-----

REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
UPPER	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				
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
				T	S	R	Q	P	O	N	M	L	K				
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