Archdiocese of Agana
196 Cuesta San Ramon, Ste. B, • Hagåtña, GU 96910
Tel: (671)472-6116
Fax: (671)477-3519

San Vicente Catholic School
Accredited by the Western Catholic Educational Association and co-accredited by the Western Association of Schools and Colleges

196 Bejong Street, Barrigada, Guam 96913
Tel: 735-4240-3
Fax: 734-8758
Web: www.svcsguam.com

ADMISSION FORM

SY 2018-2019

Note: Lost registration form packet: $5.00 fee

CRITERIA FOR ADMISSION

* A cumulative grade point average (GPA) of 70% or above
* Returning students must be cleared of all tuition fees prior to registration
* A copy of Legal court documents for students under the care of a third party other than the parents
* A child must be 3 or 4 years old by October 31st of the school year to be admitted to Pre-Kindergarten 3 or 4 and must be fully potty-trained.
* A child must be 5 years old by December 31st of the school year to be admitted to Kindergarten.

DOCUMENTS REQUIRED (at the time of registration)

NEW STUDENT	RETURNING STUDENT
* Complete Admissions Form	* Completed Admission Form
* Signed Registration Commitment Contract	* Signed Registration Commitment Contract
* Physical Examination(EVERY YEAR) and Immunization record (PPD/Skin Test within the year)	* Student Emergency/Health Information Form
* Student Emergency/Health Information Form	* Court Documents(If under Legal Guardianship)
* Report Card/SAT or ACT Aspire Scores/School Transcripts	* Please ensure physical exam and current PPD test, updated shot records are completed upon registration
* Tuition Clearance from another private school for transferees	
* Baptismal Certificate (for Catholics)	
* Birth Certificate	
* Copy of I-20 form or Passport	
* Court Documents (if under legal guardianship)	

FINANCIAL RESPONSIBILITIES

Tuition

Tuition Fees are ***NON-REFUNDABLE*** and ***NON-TRANSFERABLE***

Number	Monthly Payment		Semi-Annual Payment		Annual Payment	
of Child	W/out AOA Fee	with AOA Fee	W/out AOA Fee	With AOA Fee	w/out AOA Fee	with AOA Fee
1	$ 370.00	$ 386.90	$ 1,850.00	$ 1,934.50	$ 3,700.00	$ 3,869.00
2	$ 690.00	$ 723.80	$ 3,450.00	$ 3,619.00	$ 6,900.00	$ 7,238.00
3	$ 966.00	$ 1,016.70	$ 4,830.00	$ 5,083.50	$ 9,660.00	$ 10,167.00
4	$ 1,248.00	$ 1,315.60	$ 6,240.00	$ 6,578.00	$ 12,480.00	$ 13,156.00
5	$ 1,550.00	$ 1,634.50	$ 7,750.00	$ 8,172.50	$ 15,500.00	$ 16,345.00
6	$ 1,740.00	$ 1,841.40	$ 8,700.00	$ 9,207.00	$ 17,400.00	$ 18,414.00

*** Monthly Payments(10 months) - Payments are due on the 1st of each month. A 5% late fee will be assessed for payments made after the 5th day of the month*

Registration and other Fees are NON-REFUNDABLE/NON-TRANSFERABLE

These fees covers: Building fund, instructional materials, consumable workbooks, textbooks, auxilliary fee, and athletic fee

Fee	Amount
Early Bird Registration - per student (February 5, 2018 - May 5, 2018)	*$ 690.00*
Regular Resgistration Fee - per student (May 7, 2018)	$ 720.00
Parents/Teachers/Staff/Students Association(PTSSA) Fee - per family	$ 20.00
Archdiocesan Assessment Fee	$ 169.00
8th Grade Graduation Fee	$ 180.00

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REGISTRATION FORM
New/returning student

STUDENT INFORMATION

SCHOOL YEAR 2018-2019

Student's Name ______ Gender: M/F Grade: ______ Religion ______

Birthdate ______ Ethnicity ______ Citizenship ______

Physical Address ______ City, State, Zip Code ______

Mailing Address ______ City, State, Zip Code ______

PARENT/GUARDIAN INFORMATION

This information must be provided. Please provide a minimum of TWO emergency contacts.

1. ☐ Mother ☐ Father ☐ Legal Guardian
☐ Stepmother ☐ Stepfather ☐ Other
☐ Ms ☐ Mr ☐ Miss ☐ Mrs ☐ Dr
☐ Sole Custody ☐ Shared/Joint Custody ☐ Accrued
Is this person an EMERGENCY contact? ☐ Yes ☐ No

Last Name ______
First Name ______

Address	
City	State Zip Code
Home Phone No.	Business Phone No.
Cellular Phone No	Fax No.

Email ______

2. ☐ Mother ☐ Father ☐ Legal Guardian
☐ Stepmother ☐ Stepfather ☐ Other
☐ Ms ☐ Mr ☐ Miss ☐ Mrs ☐ Dr
☐ Sole Custody ☐ Shared/Joint Custody ☐ Accrued
Is this person an EMERGENCY contact? ☐ Yes ☐ No

Last Name ______
First Name ______

Address	
City	State Zip Code
Home Phone No.	Business Phone No.
Cellular Phone No	Fax No.

Email ______

3. ☐ Mother ☐ Father ☐ Legal Guardian
☐ Stepmother ☐ Stepfather ☐ Other
☐ Ms ☐ Mr ☐ Miss ☐ Mrs ☐ Dr
☐ Sole Custody ☐ Shared/Joint Custody ☐ Accrued
Is this person an EMERGENCY contact? ☐ Yes ☐ No

Last Name ______
First Name ______

Address	
City	State Zip Code
Home Phone No.	Business Phone No.
Cellular Phone No	Fax No.

Email ______

4. ☐ Mother ☐ Father ☐ Legal Guardian
☐ Stepmother ☐ Stepfather ☐ Other
☐ Ms ☐ Mr ☐ Miss ☐ Mrs ☐ Dr
☐ Sole Custody ☐ Shared/Joint Custody ☐ Accrued
Is this person an EMERGENCY contact? ☐ Yes ☐ No

Last Name ______
First Name ______

Address	
City	State Zip Code
Home Phone No.	Business Phone No.
Cellular Phone No	Fax No.

Email ______

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Additional Emergency Contacts

Please check the box(es) below if the emergency contacts listed below are authorized to pick up your child in the event you are unable to do so.

Name (*Last, First*): ______________________ Relation to Child: __________
Home Phone: ________________ Cell Phone:________________ Work Phone:______________

☐ *Above individual **is authorized to pick up my child** in the event I, the parent/guardian, am unable to.*

Name (*Last, First*): ______________________ Relation to Child: __________
Home Phone: ________________ Cell Phone:________________ Work Phone:______________

☐ *Above individual **is authorized to pick up my child** in the event I, the parent/guardian, am unable to.*

Name (*Last, First*): ______________________ Relation to Child: __________
Home Phone: ________________ Cell Phone:________________ Work Phone:______________

☐ *Above individual **is authorized to pick up my child** in the event I, the parent/guardian, am unable to.*

Enrollment Agreement

I understand that I am responsible for all costs (tuition fees, cafeteria, library, student store, etc.) incurred while my child is enrolled at San Vicente Catholic School. I also understand that the Registration fee, auxiliary fee, building fund, instructional & consumable textbook fees, and tuition fees are NON-REFUNDABLE/NON-TRANSFERABLE.

As the parent/guardian, I agree to give my support to the Administration of San Vicente Catholic School and abide by the terms and conditions set by the school to ensure the success of my child's Catholic education. If, at any time, I can no longer support the Administration, I will promptly withdraw my child and agree to pay any applicable fees.

I have read and fully understand the above statements and by affixing my signature, I am aware that I am bound to these conditions.

______________________ ______________________ ______________
Parent's/Guardian's Name Signature Date

______________________ ______________________ ______________
Parent's/Guardian's Name Signature Date

Photo Release

I hereby authorize San Vicente Catholic School to use my child's picture for publication in the school's website, PDN, school's brochure, U'Matuna, etc.

___ Yes ___ No Parent's/Guardian's Signature:______________________

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REGISTRATION COMMITMENT CONTRACT
SY 2018-2019

Name of Student(s) *List currently enrolled students*	**Grade Level** SY 2018-2019
1.	
2.	
3.	
4.	
5.	
6.	

Name of Parent/Guardian: ____

Upon acceptance of the registration by San Vicente Catholic School, the undersigned, agrees to pay the required fees specified in the *Enrollment Agreement* for the school year 2018-2019. I/We understand that tuition fees and registration fees along with the PTSSA fee, auxiliary fee, instructional & consumable textbooks fee, and building fund fees are NON-REFUNDABLE/NON-TRANSFERABLE.

I/We understand that the aforementioned fees do not include incidental expenses, which may include but are not limited to supplies, uniforms, and school spirit items. I/We further understand the I/We may cancel this contract in writing without penalty (except forfeiture of all fees) at any time. The registration fee, building fund fee, PTSSA fee, instructional & consumable textbooks fee, and auxiliary fee must be paid **upon registration** __________ ***Initial***

By accepting and endorsing this contract, I/We agree to meet all financial obligations incurred throughout the school year. Monthly tuition is due on the first (1st) of each month but no later than the 7th calendar day grace period. Reminder notices will be made by phone or mail. Tuition is considered delinquent if payment is not received after one month. A 5% late fee will be assessed and added to the tuition. ________ ***Initial***

I/We hereby grant permission to public photographs of our child(ren) and consent to authorize the use of photographs for all legitimate school-related purposes. ___________ ***Initial***

I/We understand that the school will not accept checks from individuals who have had one occurrence of a check returned unpaid by a bank for any reason. A returned check fee of $50.00 will be charged. ________***Initial***

I/We agree to pay, to the extent permitted by law, the school's expenses of enforcement and collection of tuition, fees, and related expenses, including, without limitation attorney's fees and costs.
_________ ***Initial***

Parent's/Guardian's Signature: ____ Date:____________

Acknowledged By: ____ Date: _____________
Mrs. Nelba R. Aquino, *SVCS Principal*

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Student's Name: ______________________________ Homeroom: ___________

PARENTAL INVOLVEMENT

San Vicente Catholic School encourages our families to participate in the growth and education of our children. Please identify any committee, services, or other areas where you would like to contribute your time or resources:

____________ Classroom/Homeroom Helper

____________ Lunch Break Activities Instructor

____________ Extracurricular Activities/Coaching

____________ Athletics (specify):_______________________

____________ Annual Fun Run

____________ Other: ______________________________

______________________________ Date: ___________

Print Name of Parent/Guardian

______________________________ Date: ___________

Signature of Parent/Guardian

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Medical / Athletic Clearance Form for *San Vicente Catholic School* — Note: *Please submit on or before 1st day of school.*

Student Name ______________________ Date ______________

Date of Birth ______________ Age __________ Ethnicity ______________

Grade Entering ______________ School Year __________

Home address ____

Home phone ______________ E-mail ______________ Physician's Name ______________

Father's name ______________ Cell Phone __________ Physician's Phone no. ______________

Mother's name ______________ Cell Phone __________ Hospital / Clinic ______________

Best number to call for emergency ______________

Part 1: Physical Examination

Height ________ Weight ________ T ________ P ________ R ________

Blood pressure ________ Vision: RT ________ LT ________ Hearing: RT ________ LT ________

Check each line	Normal	Abnormal	Not examined	Describe suspicious or abnormal findings
general appearance	☐	☐	☐	______________
Skin, hair, nails	☐	☐	☐	______________
Eyes: external (pupils-cornea)				______________
Optic fundus	☐	☐	☐	______________
Muscle balance	☐	☐	☐	______________
Ears: external				______________
Auditory acuity	☐	☐	☐	______________
Tympanic membrane	☐	☐	☐	______________
Tympanogram	☐	☐	☐	______________
Pure tone	☐	☐	☐	______________
Nose, mouth	☐	☐	☐	______________
Pharynx, larynx	☐	☐	☐	______________
Speech	☐	☐	☐	______________
Teeth, gums	☐	☐	☐	______________
Neck, lymph nodes	☐	☐	☐	______________
Thyroid	☐	☐	☐	______________
Cardiovascular	☐	☐	☐	______________
Respiratory	☐	☐	☐	______________
Gastrointestinal	☐	☐	☐	______________
Genito-urinary	☐	☐	☐	______________
Musculo-skeletal	☐	☐	☐	______________
Scoliosis screening				______________

Part 2: Immunization Record: Please attach a copy of updated immunization record.

Please check one: ☐ In Good Health ☐ Specific Problem(s) Noted ☐ Child with a disability – Please Specify: __________

This child is physically fit to participate in physical education and/or athletic events and related activities. ☐ yes ☐ no

Name of Physician (print) ______________________ Signature ______________ Date __________

Clinic ______________________ Email address ______________

PPD date given: ______________ PPD date read: ______________ Result: __________

Parental /Guardian Consent

I hereby give permission for the physician to examine my child so that he/she may obtain medical clearance to participate in athletic activities. Therefore, neither the examining physician nor the school is to be held liable for any abnormalities not detected in this examination. Permission is also granted to my child (name) ______________________ to participate in the athletic activities approved by the physician as initialed below for school year: __________.

Parent/Guardian Signature ______________________ Date __________

Medical Information:

To be completed by Parent or Legal Guardian

Last name:____________________ First name:____________________ Middle name:____________________

<u>Medical History</u>: Please check "No" or "Yes" appropriately.

		No	Yes
Allergies: Food, medication, etc	if yes, when? __________	☐	☐
Heart problems or heart disease	if yes, when? __________	☐	☐
Chest pains	if yes, when? __________	☐	☐
Asthma	if yes, when? __________	☐	☐
Shortness of breath	if yes, when? __________	☐	☐
Head injuries	if yes, when? __________	☐	☐
Fractures	if yes, when? __________	☐	☐
Weak joints or back problems		☐	☐
Taking medication	if yes, when? __________	☐	☐
Surgery	if yes, what type? __________	☐	☐
Blood disorder		☐	☐
Hernia		☐	☐
Rheumatic fever		☐	☐
Diabetes		☐	☐
Hearing problems	if yes, when? __________	☐	☐
Vision problems: Glasses/contacts needed		☐	☐
Convulsions/seizures or breathing spells	if yes, when? __________	☐	☐
Other serious injury or illness?	If yes, please explain below.	☐	☐

Remarks:

____

____

____

____

To the best of my knowledge, the information on this page is accurate and complete.

Signature of Parent or Guardian ______________________________ Date ____________________

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STUDENT EMERGENCY & HEALTH INFORMATION

SY2017-2018

Name (Last, First, Middle)	Gender	D.O.B.	Mother Ethnicity	Grade / Room

Physical Address	Home Phone

[ ] Mother's [ ] Guardian's Name		[ ] Father's [ ] Guardian's Name	
Place of Work	Work Phone	Place of Work	Work Phone
Home Phone #	Other Contact #	Home Phone #	Other Contact #

Who should be contacted first?

Significant Health History

Problems	Year	Yes	No	Comment	Problems	Year	Yes	No	Comment
Asthma					Seizures				
Chicken Pox					Speech Problems				
Diabetes					Skin Problems				
Ear Infections					Vision Problems				
Emotional Problems					Wears Glasses/ Contacts				
Fractures					Tuberculosis				
Hearing Loss					Rheumatic Fever				
Head Injuries					Hospitalizations				
Heart Problems					Other Problems				

Allergies: [ ] Food [ ] Drugs [ ] Other Name of Allergies: ____________________ Reactions: ____________

Is your child taking any medication daily? [ ] Yes [ ] No Name of Medication: ______________________

Reason/ Diagnosis for Medication: ____

Date your child received his/her last DPT/ DT/ Td: ______________ Height: ________ Weight: ________

Name of Physician: ______________________________ Health Insurance: __________________________

In case of emergency, I give permission to the local ambulance to transport my child to:

[ ] GMH [ ] Naval Hospital [ ] Other (specify): ____

Emergency Consent

In case of emergency, and the school cannot contact the mother, father, or guardian, please name two other individuals you authorize the school to call.

	Last Name/ First Name	Relationship to Child	Contact Number
1.	____________________	____________________	____________________
2.	____________________	____________________	____________________

I understand if any information on this form should change, I must notify the school. immediately

Parent's / Guardian's Signature: ______________________________ Date: ________________

Student File – Nurse's Copy