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 Phone: 671.735.4240 Fax: 671.734.8718

REGISTRATION CHECKLIST **1**
SY 2020-2021

___ Registration Form
___ Registration Commitment Contract
___ Birth certificate
___Baptismal/Reconciliation/First Holy Communion Certificate
___Report Card/SAT Result/ACT Aspire Results
___ Court Documents (if under legal guardianship
___ Immunization Shot Record
___ Student Emergency & Health Information
___ Medical Clearance Form
___ Parental Involvement Form
___ Other _____

Verified by: Ms. L. Benavente

Date:_____

REGISTRATION CHECKLIST **2**
SY 2020-2021

___ Registration Form
___ Registration Commitment Contract
___ Birth certificate
___Baptismal/Reconciliation/First Holy Communion Certificate
___Report Card/SAT Result/ACT Aspire Results
___ Court Documents (if under legal guardianship
___ Immunization Shot Record
___ Student Emergency & Health Information
___ Medical Clearance Form
___ Parental Involvement Form
___ Other _____

Verified by: Main Office

Date:_____

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REGISTRATION CHECKLIST **3**
SY 2020-2021

___ Registration Form
___ Registration Commitment Contract
___ Birth certificate
___Baptismal/Reconciliation/First Holy Communion Certificate
___Report Card/SAT Result/ACT Aspire Results
___ Court Documents (if under legal guardianship
___ Immunization Shot Record
___ Student Emergency & Health Information
___ Medical Clearance Form
___ Parental Involvement Form
___ Other _____

Verified by: Health Counselor

Date:_____

REGISTRATION CHECKLIST **4**
SY 2020-2021

___ Registration Form
___ Registration Commitment Contract
___ Birth certificate
___Baptismal/Reconciliation/First Holy Communion Certificate
___Report Card/SAT Result/ACT Aspire Results
___ Court Documents (if under legal guardianship
___ Immunization Shot Record
___ Student Emergency & Health Information
___ Medical Clearance Form
___ Parental Involvement Form
___ Other _____

Verified by: Principal/Vice-Principal

Date:_____

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REGISTRATION COMMITMENT CONTRACT
SY 2020-2021

Name of Student(s) *List currently enrolled students*	**Grade Level** SY 2020-2021
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 2019-2020.

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._____ ***Initial***

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 that 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. (Please see handbook page 4: Tuition-B 1 to 4). 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: _____
Principal/ Vice-Principal

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REGISTRATION FORM
SY 2020-2021

*Note: Please type or **print** legibly in blue/black ink.*

Student Information

Student's Name: _____ Gender: M/F Grade: _____ Religion: _____
Birthday: _____ Ethnicity: _____ Citizenship: _____
Physical Address: _____ City, State, Zip Code: _____
Mailing Address: _____ City, State, Zip Code: _____

Parent/Guardian Information

1st Parent/Guardian

First Name: _____ Email: _____
Last Name: _____ Occupation: _____
Relation: _____ Place of Employment: _____
Home Phone: _____ Physical Address: _____
Work Phone: _____ City State Zip: _____
Cell Phone: _____ Marital Status: _____

2nd Parent/Guardian

First Name: _____ Email: _____
Last Name: _____ Occupation: _____
Relation: _____ Place of Employment: _____
Home Phone: _____ Physical Address: _____
Work Phone: _____ City State Zip: _____
Cell Phone: _____ Marital Status: _____

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/Guardian's Signature: _____

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Additional Emergency Contacts

Please check the box(es) below if the emergency contacts listed 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 (re-enrollment), consumable textbooks, and miscellaneous fees are non-refundable.

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

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STUDENT EMERGENCY & HEALTH INFORMATION (SY 2020-2021)

NAME (LAST, FIRST, MIDDLE)	GENDER	DOB	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 medications 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. _____	_____	_____

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Authorization to Release Child

I hereby give permission for San Vicente Catholic School, to release my child to any of the following individuals, in the event that I am unable to pick my child up. I understand the school will not release my child to anyone unless they are listed below or submit a written permission signed by the parent or guardian.

	Last Name/ First Name	Relationship to Child	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Date	Time In	Complaint	Treatment	SIR/IR/HIR	Parent Called	Nurse Initial	Time Out

Abbreviations:

RTC= Return to Class SH=Sent Home T= TemperatureHLS=Head Lice Screen

SIR= Student Injury Report IR= Illness Report HIR= Head Injury

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Medical / Athletic Clearance Form for *San Vicente Catholic School* SY 2020-2021

Note: P*lease 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 _____ _____

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 attached 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: _____

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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:_____

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's Name:_____ Homeroom:_____

PARENTAL INVOLVEMENT **SY 2020-2021**

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

_____ Catholic Schools Week

_____ Other: _____

_____ Date: _____

Print Name of Parent/Guardian

_____ Date:_____

Signature of Parent/Guardian