

RETURNING RESIDENT STUDENT (U.S. and International) ENROLLMENT FORMS CHECK LIST

Please complete and return by August 1, 2009:

- Travel and School Vacation Information Form
- Student/Parental Authorization Form
- Authorization for Administration of Medications Form
- Physician's Order for Administration of Medications Form
- Public Relations Information Form
- Family Information Form
- Consent to Treat/Field Trip Perm./Insurance Info./Emergency Contact Form
- Student Health Information Form
- Physical Examination Form (District 742)—required every three years
- Pupil Immunization Record Form
- Minnesota State High School League Athletic Eligibility Form (if applicable)

If you have any questions, please call the Main Office at (320) 363-3315 ~1-800-525-7737 or E-mail to us at gschneider@csbsju.edu.

Please mail completed forms to:

Saint John's Preparatory School
Main Office
1857 Watertower Road, Box 4000
Collegeville, MN 56321-4000

SJP RESIDENT STUDENT FALL TRAVEL PLANNING FORM

SECTION II: TRAVEL AND SCHOOL VACATION INFORMATION

(Refer to Residence Information Booklet Section IIA for details)

Student Name: _____

ARRIVAL PLANS FOR START OF SCHOOL: (New international students arrive on August 18th; U.S. resident students (new and returning) and returning international students arrive on August 22nd)

Airport (select one):

- Minneapolis/St. Paul International Airport (MSP)~ Airline: _____ Flight #: _____
 St. Cloud (STC) _____ ~ Airline: _____ Flight #: _____

Date and Arrival Time: _____

Ground travel to SJP:

SJP transportation for new international students on Tuesday, August 18, 2009. Please try to arrive to the airport between 6:00AM and 5:00PM. SJP will assist in arranging ground transportation from the Minneapolis/St. Paul International Airport through Executive Express, a local shuttle service. SJP staff will meet new students at the airport.

For any other arrival dates, you will need to make your own arrangements for travel to Saint John's Prep. Please let us know your other arrangements. Options include:

- Executive Express (www.executiveexpress.com)
 Taxi
 Other: _____

(Please submit a copy of your airline ticket or airline confirmation page.)

**DEPARTURE PLANS FOR CHRISTMAS BREAK (December 18 after 3:00 PM or on December 19, 2009).
RESIDENCE HALLS CLOSE AT 10:00AM ON DECEMBER 19th.**

Destination _____ Airline: _____ Flight: _____

Date and departure time: _____

Ground travel from SJP: Executive Express Taxi Other: _____

(Please submit a copy of your airline ticket or airline confirmation page.)

RETURN PLANS FOR JANUARY 4, 2010 BEFORE 9:00 PM.

Destination _____ Airline: _____ Flight: _____

Date and departure time: _____

Ground travel from SJP: Executive Express Taxi Other: _____

(Please submit a copy of your airline ticket or airline confirmation page.)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS 2009-2010

(Refer to Residence Information Booklet section III F for details.)

Parents of resident students requesting that medication be administered to their son/daughter in the residence halls of Saint John's Preparatory School by trained residence staff are required to provide to the school: (1) Physician's Order; (2) Parental Request and Release; (3) Medications supplied in original labeled prescription bottle. (This information is to be supplied each new school year or with each new prescription.)

Student's Name: _____ Date of Birth: _____

Residence Hall (circle one): Richarda Hall (Girls) Saint Michael Hall (Boys)

Home Address: _____

The following over-the-counter medications will be available to your child on an as-needed basis and as directed by the manufacturer. Please cross out any that should NOT be offered:

Tylenol Halls Cough Drops Tums Ibuprofen Aleve

PARENT'S REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

Prescription Medication:

I request and authorize designated residence hall staff to give medication/s to my son/daughter

_____.
I release Saint John's Preparatory School from any liability should reactions result from the medications. I give the Saint John's Health Center or the residence hall designee permission to contact my attending physician/dentist regarding the medication.

Medication Policy: I have read, understand and agree to the medication policy (Refer to Residence Information Booklet Section III, Letter F).

Parent/guardian signature

Date

**PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATIONS
2009-2010**

(Refer to Residence Information Booklet section III F for details)

This form is required for each prescription medication prescribed prior to or during the school year.

Student's Name: _____

I have prescribed the following medication for this student and request these dosages to be given.

Medication Name: _____ Dose: _____

Time and frequency of dosage: _____

For the treatment of: _____

Possible side effects: _____

Special instructions: _____

If an inhaler, may this student carry it with him/her? Yes No

Special instructions: _____

Last date to be given: _____

Physician's Signature: _____

Date: _____ Phone Number: _____

Print physician's name and office address: _____

Please return a separate copy for each medication. Thank you.

**PUBLIC RELATIONS INFORMATION FORM
2009-2010**

STUDENT NAME: _____ Current Grade: _____

_____ Current Grade: _____

_____ Current Grade: _____

- I hereby permit Saint John's Preparatory School to use, in whole or in part, photographs, videos, written extractions, and voice recordings of my child for the purpose of illustrations, publications and websites.
- I hereby permit Saint John's Preparatory School to notify local newspapers of my child's academic, athletic or other special achievements.

What newspaper(s) do you wish to have press releases sent to?

Newspaper Name: _____

Address: _____

City, State, Zip: _____

Saint John's Prep offers regular E-mail updates to parents, including emergency notifications (weather cancellations, etc.).

What E-mail address(es) would you like these updates sent to?

Parent/Guardian Signature

Date

FAMILY INFORMATION FORM SCHOOL YEAR 2009-2010

Please complete this form in conjunction with all others and return it to the Prep School. If you have more than one child enrolled, it is not necessary to complete more than one form.

Student(s) Name(s): _____ Year of Graduation: _____
 _____ Year of Graduation: _____
 _____ Year of Graduation: _____

FATHER/ MALE GUARDIAN:

Full Legal Name: _____ Preferred/ Nickname: _____
 Preferred Title: _____ Date of Birth: _____
 Complete Street Address: _____
 City/ State/ Zip: _____
 Home Telephone: _____ E-Mail: _____ Cell: _____
 Work Organization Name: _____ Position/ Title: _____
 Work Street Address: _____
 Work City/ State/ Zip: _____
 Work Telephone: _____ E-Mail: _____ Cell: _____

MOTHER/ FEMALE GUARDIAN: (Put "Same" for spaces that are identical to above)

Full Legal Name: _____ Preferred/ Nickname: _____
 Preferred Title: _____ Date of Birth: _____
 Complete Street Address: _____
 City/ State/ Zip: _____
 Home Telephone: _____ E-Mail: _____ Cell: _____
 Work Organization Name: _____ Position/ Title: _____
 Work Street Address: _____
 Work City/ State/ Zip: _____
 Work Telephone: _____ E-Mail: _____ Cell: _____

STUDENT'S PATERNAL GRANDPARENTS: (Please complete even if grandparent(s) is/are deceased)

Full Legal Name **Grandfather:** _____ Preferred/ Nickname: _____
 Preferred Title: _____ Date of Birth: _____ Work/ Retired? _____
 Full Legal Name **Grandmother:** _____ Preferred/ Nickname: _____
 Preferred Title: _____ Date of Birth: _____ Maiden Name? _____
 Complete Street Address: _____
 City/ State/ Zip: _____
 Home Telephone: _____ E-Mail: _____ Other/Work: _____
 Work Organization Name (former, if retired): _____ Position/ Title: _____

STUDENT'S MATERNAL GRANDPARENTS: (Please complete even if grandparent(s) is/are deceased)

Full Legal Name **Grandfather:** _____ Preferred/ Nickname: _____
 Preferred Title: _____ Date of Birth: _____ Work/ Retired? _____
 Full Legal Name **Grandmother:** _____ Preferred/ Nickname: _____
 Preferred Title: _____ Date of Birth: _____ Maiden Name? _____
 Complete Street Address: _____
 City/ State/ Zip: _____
 Home Telephone: _____ E-Mail: _____ Other/Work: _____
 Work Organization Name (former, if retired): _____ Position/ Title: _____

2009-2010 CONSENT TO TREAT/FIELD TRIP PERMISSION/ INSURANCE INFORMATION/EMERGENCY CONTACT FORM

Student Name: _____

Date of Birth: _____

Current Grade: _____

Consent to Treat: The law requires that parent/guardian permission be obtained for procedures on minors and for *release of information* for insurance purposes. A situation may arise in which treatment, hospitalization or immunizations are necessary. Saint John's Preparatory School staff will make every attempt to communicate with you, if possible, and will use this authority only with the expressed request of a qualified licensed physician, nurse or medical personnel. No major operation will be performed, except in an emergency, without parent/guardian being contacted and fully informed. Immunizations may be given to boarding students requiring further vaccines at the Saint John's University Health Center or Stearns County Public Health Office with parent/guardian permission.

In the event of a medical, surgical or immunization need, including influenza vaccine, for the above named Saint John's Preparatory School student, I/we hereby authorize the performance upon said student of such medical, surgical or immunization procedures and *release of information* as may be prescribed by the school nurse or physician licensed to practice medicine and surgery. I authorize the release of any medical/pharmacy information necessary to process a claim for payment.

Parent/Guardian Signature

Date

Field Trip and Off-Campus Activities Permission Form: I/we, give our permission for the above named student to participate in activities, field trips, sports, or other school-related activities which take place off Saint John's Preparatory School premises. In consideration of this permission granted to my child to participate in previously mentioned activities, I release and hold harmless the school, its agents, employees, and officers, from any and all actions or causes of action of any nature for personal injury or property damage of any kind arising in any way from my child's participation. I further acknowledge that this release is binding upon my heirs, successors or assigns, that I have read the foregoing and understand its significance, and that I have executed this document voluntarily.

Furthermore, I/we agree that if the above named student's behavior is inappropriate, unsafe and/or detrimental to the group, I will be contacted immediately to secure means of removing my child/ward from the event premises, I understand that any financial costs incurred as a result of my child/ward being sent home are my responsibility.

Parent/Guardian Signature

Date

Insurance Data: My son/daughter/ward is covered for medical, hospitalization and/or accident insurance under the following policy. I understand that this information will be used in the event of sickness, accident, or hospitalization. I authorize the release of any medical/pharmacy information necessary to process a claim for payment. **Please attach a copy of the primary insurance card.**

Policy Holder's Name: _____

Insurance Company Name: _____

Insurance Company Address: _____

Policy #: _____ Group #: _____ Insurance Company Phone #: _____

Day and U.S. Resident Students: Saint John's Prep requires all enrolled students to have insurance coverage. If you do not have insurance coverage, information regarding the Student Health Insurance carried by Saint John's Preparatory School will be sent out as requested from the Student Accounts Office (320) 363-3302.

International Students: Saint John's Prep automatically enrolls all international students in the Student Health Insurance Plan.

EMERGENCY CONTACT INFORMATION – Page 2 of Consent to Treat Form

Student Name: _____ **Date:** _____

Parent/Guardian and Emergency Contact Information:

Student lives with: () Both parents () Father () Mother () Other _____

Is this student enrolled as a Resident/Boarding student? () Yes () No

Father's/Guardian's Name:	Daytime Phone Number	Evening Phone Number	Cell Phone Number
Mother's/Guardian's Name:	Daytime Phone Number	Evening Phone Number	Cell Phone Number

Non-Custodial Emergency Contact: (International students, please list a contact in the U.S. if available.)

In case of an accident or illness and school personnel are unable to contact parent/guardian, contact:

Name:	Daytime Phone Number	Evening Phone Number	Cell Phone Number
Name:	Daytime Phone Number	Evening Phone Number	Cell Phone Number

****Please inform your contacts that you are using their name for this purpose!****

These next questions may have been requested on another form, but in case of an emergency, we will refer to this form first. The following responses would be helpful in case a student needs emergency medical care:

Date of Student's Last Tetanus Immunization: _____

Allergies: _____

Medications regularly taken: _____

Student Health Information Overview 2009 – 2010

This form is a vital resource to the SJP staff and is used throughout the school year. Saint John's Prep School contracts with the St. Cloud Community School District 742 for health services. The State of Minnesota has specific legislation in place that addresses the mandated health requirements for all students attending schools within the State of Minnesota.

In order for Saint John's Preparatory School to ensure a safe environment for your son/daughter/ward, students will not be allowed to attend classes until the school has received completed, signed copies of all required health forms.

***** PLEASE RETURN THE FORMS NOTED BELOW BY AUGUST 1, 2009 *****

1. **Consent to Treat/Field Trip Permission/Insurance Information/Emergency Contact Form.** This is a REQUIRED form that will be used for field trips, athletic teams and the Main Office as a resource for emergency situations. It is imperative that the school has the most up-to-date contact information.
2. **Health Information Form.** This form alerts SJP if your son/daughter/ward has any health concerns which the staff at school should be aware of.
3. **Physical Examination Form (District 742).** Physicals performed by your family physician are required for all new students and every three (3) years for returning students.
4. **Pupil Immunization Record (for new students).** Each student's immunizations MUST be current by the first day of school, according to Minnesota State Law 123.70. The month, day and year for each immunization must be documented and returned to school by August 1, 2005. The requirements for grades 7 through 12 are:
 - a. 3 Diphtheria, Tetanus, Pertussis (DTP) – 1 Td booster vaccine is required by age 11 or older
 - b. 3 Polio
 - c. 2 Measles, Mumps, Rubella (MMR)
 - d. 3 Hepatitis B
 - e. 1 Varicella: New requirement for 7th grade students onlyRecommended but not required:
 - f. Tuberculosis screening (Mantoux Skin Test): a tuberculosis screening is recommended for all U.S. students, but it is not required. Dates of tests should be one month prior to attendance at Saint John's Preparatory School and verified by a physician.
 - g. Meningitis: This is recommended, but not required.
5. **Medications.** If your son/daughter/ward will be receiving medications (either self-medicated or dispensed by a school official), Saint John's Preparatory School will require further information and you will be contacted by either the Dean of Students or by the school nurse.
6. **Screenings.** If you suspect that your son/daughter/ward is having a problem with his/her vision or hearing, please take your child in for either a vision or hearing exam. Please send a copy of the doctor's report so this information can be included in your son or daughter's health record here at school.

Please feel free to contact me with your questions at any time during the school year by leaving a message at the Prep School Student Account Office (320) 363-3302, or e-mailing Sandy Ernst at sernst@csbsju.edu.

Sincerely,

Myra Schrup

School Nurse

STUDENT HEALTH INFORMATION FORM Academic Year 2009-2010

Student Last Name	First	M.I.	Grade 2009-2010
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Check below any and all items that the school should be aware of:

- | | | |
|--|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Bee Sting/Insect Bite | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Food/Specify | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Glasses |
| | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Self Injurious Behavior |

Does your child have any other health conditions which the school needs to be aware of, other than what is listed above?

Yes No.

If yes, please explain: _____

Does your child require any special procedures? (nebulization, use of glucometer, epi-pen, etc.) _____

Has your child had a physical examination within the last year? Yes No

Heath Physical Completed or will be completed on (date): _____ / _____ / _____

Has your child had a dental examination within the last year? Yes No

Has your child had an eye examination within the last year? Yes No

Is your child now under a doctor's care? Yes No

If yes, please explain: _____

List dates and type of any immunizations or evaluations given in the past year: _____

Is your child taking any medicine that may affect his/her school performance? Yes No

Name of Medication(s) and reason for taking _____

****Medication may be brought to school for administration only with a written consent from a parent. All medication administered in school will require a written order by a licensed healthcare provider. Medication to be administered must be brought to school in the container labeled by the pharmacy or physician.**

Check below if your child has used or may need any of the following services:

None Required Assistance Counseling Services Special Diet Requirements Speech/Language

Tutor Services Other (specify) _____

Signature of Parent/Guardian

Date

PHYSICAL EXAMINATION FORM (District 742)

**Physical exams records are required for all new students and every three years for returning students.
Please send form to Saint John's Preparatory School by August 1, 2009**

This form is confidential.

Name _____ Male _____ Female _____ Birthdate _____
 Address _____ Phone _____
 Parent/Guardian _____
 Doctor _____ Dentist _____
 Last physical exam _____ Last dental exam _____

Significant Past History

Allergy (specify)	ADHD ADD
Asthma	Developmental Delay
Chicken Pox (Disease)	Seizure History
Congenital Defect (specify)	Vision Glasses _____ Contacts _____
Diabetes	Hearing
Heart Condition	Surgeries (specify) T & A Myringotomy Tubes, Hernia
Neurologic (specify)	
Orthopedic (specify)	Other

Health Examination (To be completed by Physician.)

Examining Physician's Name (Print) _____
 Ht. _____ Wt. _____ Pulse _____ BP _____ Urinalysis _____ HGB _____
 Eyes _____
 Ears _____ Orthopedic/Scoliosis _____
 Nose _____ Skin _____
 Throat _____ Allergies (if so, what?) _____
 Glands _____
 Lungs _____ Nutrition _____
 Heart _____ Serious Illnesses _____
 Nervous System _____

Please review/record immunizations on reverse side and update for school requirements as needed.

Does student require medication on a daily or episodic routine?

Name of medication: _____

Dose: _____ Frequency: _____

Condition being treated: _____

*Please include separate doctor's order if medication will be taken at school.

Significant Development History _____

History of: Hearing Problem _____ Speech Problem _____

History of: Social or Emotional Problem _____

List conditions which may limit participation in:

A. Classroom activity _____

B. Physical education _____

C. Competitive sports _____

Any special health problems, recommendations and/or comments _____

Approved for: Full Activity _____ **Limited Activity** _____

Date _____ **Examining Physician** _____ **M.D.**

I hereby release this information to the Health Service of District 742 and give the licensed school nurse permission to clarify the information with the Physician if the need arises.

PARENT/GUARDIAN SIGNATURE

Pupil Immunization Record

Name _____ Birthdate _____

Minnesota Statutes Section 121A.15 requires children enrolled in a Minnesota school to be immunized against certain diseases, allowing for specified exceptions. This form is designed to provide the school with information required by the law and will be available for review by the Minnesota Department of Health and the local community health board.

Enter the MONTH, DAY, and YEAR for all vaccines the pupil received.

Type of Vaccine	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Diphtheria, Tetanus, and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) - pediatric formulation (<7 yrs)					
Tetanus and Diphtheria (Td) . adult formulation (7yrs)					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) (minimum age: 12 mos)					
Hepatitis B (hep B)*					
Varicella (chickenpox)**					
Proof of Freedom from Tuberculosis U.S. students encouraged to provide, REQUIRED for all international students.	Mantoux Skin Test Date given	Mantoux Skin Test Date Read	Mantoux Skin Test Results (Record in millimeters)	Chest X-ray Date Taken (Copy of x-ray must be attached)	
Meningitis Recommended, not required	Vaccinated Month & Year				

* Hepatitis B is required for kindergarten and 7th grade.

** Varicella vaccine has been required since fall 2004.

Indicate immunization status and source of above information by choosing one of the following:

I certify that this student has received all immunizations required by law.

Signature of parent/guardian or physician/public clinic

Date

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B (K + 7th), varicella (K + 7th), measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months. The dates on which the remaining doses are to be given are:

Signature of physician/public clinic

Date

Medical exemption: No student is required to receive an immunization if they have a medical contraindication or laboratory evidence of immunity. To receive a medical exemption, a physician must sign the following statement:

I hereby certify that immunization is contraindicated for medical reasons or that laboratory confirmation of adequate immunity exists for the following immunizations:

Signature of physician

Date

Conscientious exemption: No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized:

I hereby certify by notarization that immunization for my child is contrary to my conscientiously held beliefs. Indicate vaccine(s): _____

Signature of parent or legal guardian

Date

Subscribed and sworn to before me this _____ day of _____ 20____

Signature of notary

History of varicella disease: *I hereby certify that this child had chickenpox disease on this date:* _____
(MO/YR) and therefore does not need a varicella shot.

Signature of parent/legal guardian or physician/public clinic

Date

Additional exemptions

o **Students in grades 7-12:**

A Td booster at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose. Enforcement of the Td booster requirement was reinstated in the fall of 2004 for all 7th-12th graders.

o **Students 11-15 years of age:**

A 3rd dose of hepatitis B vaccine is not required for those students who provide documentation of the alternative 2-dose schedule.

o **Students 7 years of age or older:**

Do not need pertussis vaccine.

o **Students 18 years of age or older:**

Do not need polio vaccine.



Minnesota State High School League

2100 Freeway Boulevard, Brooklyn Center, MN 55430-1735 (763) 560-2262

If you plan to participate in a sport during the 2009-2010 school year, you must complete an eligibility form.

This form is listed on the Minnesota State High School League site at www.mshsl.org, then click the Resources tab, select forms, select eligibility then scroll down to Athletic Eligibility Brochure 2009-2010.

This form is available in a pdf or word format. You choose which would work best for you. The 2009-2010 MSHSL Athletic Eligibility Statement (last two pages) is the portion that needs to be completed and returned.