Our Lady of the Rosary School

10701 SW 95 Street, Miami, FL 33176-2612 305-271-8389
www.olrschoolmiami.com/www.olrschool@gmail.com

APPLICATION FOR ELEMENTARY SCHOOL

Child's Legal Last Name: _____ Child's Legal First Name: _____Middle Initial: ___

Child's Date of Birth: _____ Social Security #:_____ Gender: _____

Home Address: _____
City: _____ State: _____ Zip: _____

Billing Address: (If different from home address) _____

The child lives with: _____ Legal Guardian(s):_____

Last School Attended: _____

Mother's Marital Status: Married__ Single__ Separated__ Divorced__ Remarried__ Widowed__

Father's Marital Status: Married__ Single__ Separated__ Divorced__ Remarried__ Widowed__

Mother Authorized to pick up? _____ Father Authorized to pick up? _____

If either parent is NOT authorized to pick -up, Our Lady of the Rosary School must be provided with legal documentation stating so.

Mother's Information

Last Name: _____ First Name: _____ Social Security#_____

Home Address: _____
City: _____ State: _____ Zip: _____

Cell Phone: _____ Email (Important): _____

Employer Name: _____Occupation: _____ Work Phone#_____

Address: _____
City: _____ State: _____ Zip: _____

Father's Information

Last Name: _____ First Name: _____ Social Security#_____

Home Address: _____
City: _____ State: _____ Zip: _____

Cell Phone: _____ Email (Important): _____

Employer Name: _____Occupation: _____ Work Phone#_____

Address: _____
City: _____ State: _____ Zip: _____

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EMERGENCY CONTACT / AUTHORIZATION TO RELEASE FROM OLR SCHOOL FORM

List below those persons who you authorize to pick up from school both during school hours and aftercare. This information is the responsibility of the child's parent(s) to keep up to date and accurate. If at any point any person(s) on the authorization to release list are to be taken off, the parent(s) must provide OLR School written notification to do so.

1. Authorized Person: _____ Relationship to Child:_____
   Phone:_____

2. Authorized Person: _____ Relationship to Child:_____
   Phone:_____

3. Authorized Person: _____ Relationship to Child:_____
   Phone:_____

4. Authorized Person: _____ Relationship to Child:_____
   Phone:_____

5. Authorized Person: _____ Relationship to Child:_____
   Phone:_____

In the case of an emergency, when the parent(s) cannot be reached, OLR School will use the Authorized pick up list as the Emergency Contacts; unless otherwise requested in writing by the parent(s).

If there is anyone who the parent(s)/legal guardian of this child wish to be an Emergency Contact, yet if it is not authorized to pick-up, written notification with specific instruction must be provided.

Authorized Person: _____ Relationship to Child: _____
Phone: _____

OLR School will contact the person(s) on this list in order of from top of the list to the bottom of the list. Please fill out accordingly.

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PARENTAL PERMISSION FOR RELEASE OF RECORDS

Student's Name: _____ DOB: _____

Name of School Releasing Records: _____

School's Address: _____

_____

Records to be released:

1. Transcript
2. Standardized Test Scores
3. Attendance Records
4. Any Psychological Testing Reports
5. Report Cards

I _____ hereby grant permission for the release of the above listed records for my child.

_____ _____

Signature of the Parent or Guardian Date

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ANAPHYLAXIS/ALLERGIES REACTION INFORMATION FROM PARENT

Student Name: _____ Date of Birth: _____ Sex:____
Parent/Guardian:_____ Phone (H):_____ Phone (W): _____Phone (Cell):_____
Parent/Guardian: _____ Phone (H):_____ Phone (W): _____Phone (Cell):_____
Child's Physical Address: _____ Zip Code: _____
List all medications:
Home: _____

School: _____

What date did your child have their first anaphylactic/allergic reaction? _____

How many anaphylactic/allergic reactions has your child had since the first reaction? _____

- **Has your child been hospitalized due to an anaphylactic/allergic reaction?** Yes___ No ___

Does your child have an Epinephrine auto-injector? Yes____ No____

Does your child have asthma? Yes ____ No ____

What triggers an anaphylactic/allergic reaction in your child? (Check all that apply)

- Bee/Wasp Sting
- Ant Bite
- Other Insect Sting
- Peanuts
- Tree nuts
- Other nuts
- Wheat
- Soy
- Milk
- Eggs
- Fish
- Shellfish
- Other Foods:
- Other Foods:
- Other Foods:
- Plants, Flowers, Cut Grass, Pollen
- Other:
- Other:

Describe the symptoms your child experiences before or during an anaphylactic/allergic reaction. (Check all that apply)

- Hives
- Difficulty Breathing
- Paleness
- Complaint of tingling, itchiness, or metallic taste in the mouth
- Vomiting
- Cramps/Stomach Pain
- Diarrhea
- Swelling/itching of the mouth or throat area
- Loss of consciousness
- Other:
- Other:

Authorization for Release of Medical Information: I hereby authorize _____to furnish
(Clinic/Provider)
anaphylactic/allergic reaction related information regarding my child _____to the Student Health
(Student's Name)
Services personnel at _____.
(School)

_____ _____ _____
Parent/Guardian **Print Name** **Date**

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FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____DOB: _____

I authorize any staff in the Our Lady of the Rosary facility that is trained in the basics of first aid to give my child first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize Our Lady of the Rosary School to transport my child to the nearest medical care facility and/or to_____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____

Address: _____ Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Emergency Contacts (in order to be contacted):

1. Authorized Person: _____ Relationship to Child:_____
   Phone:_____
   Do you give permission for your child to be released to this person? _____Yes _____ No
2. Authorized Person: _____ Relationship to Child:_____
   Phone:_____
   Do you give permission for your child to be released to this person? _____Yes _____ No
3. Authorized Person: _____ Relationship to Child:_____
   Phone:_____
   Do you give permission for your child to be released to this person? _____Yes _____ No
4. Authorized Person: _____ Relationship to Child:_____
   Phone:_____
   Do you give permission for your child to be released to this person? _____Yes _____ No
5. Authorized Person: _____ Relationship to Child:_____
   Phone:_____
   Do you give permission for your child to be released to this person? _____Yes _____ No

_____ _____

Parent's Signature Date

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AUTHORIZATION FOR AN EMERGENCY TREATMENT

Permission to any and all personal including, but not limited to employees, volunteers and visitors to take whatever steps may be necessary for medical care of an emergency, is hereby given. I understand that the order of actions taken will follow the outline below unless there is a need for immediate action, but will not be limited to these actions.

1. Parent or Guardian will be called.
2. Child's Physician will be called.
3. Contact person will be called (those that parents have listed).
4. If none of these efforts are successful:
   a.) Another physician will be called.
   b.) An ambulance will be called.
   c.) The child will be taken to the emergency room of: **Baptist Hospital (Children's ER)**
5. In order for the school to assume responsibility for my child. I understand that I must sign the child in and out at departure time.

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

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CONSENT FOOD FORM FOR SCHOOL ACTIVITIES

I, _____(parent/guardian printed name), give permission for my son/daughter _____ (child's name) to eat any food given in special occasions and/or school activities.

YES, I AGREE (SIGN BELOW): **NO, I DO NOT AGREE (SIGN BELOW):**

_____ _____

Parent/Guardian signature Date Parent/guardian signature Date

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PERMISSION TO VISIT ST. CATHERINE OF SIENA CHURCH

I, _____(parent/guardian printed name), give permission for my son/daughter _____ (child's name) to visit St. Catherine of Siena Catholic Church for approximately 20-30 minutes of prayer and song. This visit is usually once a week, but it is not limited to once per week.

_____ _____

Parent/Guardian signature Date

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PERMISSION TO PHOTOGRAPH AND POST

I,_____, give consent for my child _____to have Our Lady of the Rosary School's Faculty, staff, contracted photographers, parents and relatives to photograph, video, and post on Our Lady of the Rosary School's website and/or social media pictures that included, but are not limited to: class activities, special events, regular school days, and school projects. This helps our Lady of the Rosary School enrichment and commemorates our student's experiences.

_____ _____

Parent/Guardian's signature Date

_____

Parent/Guardian's Printed Name

_____ _____

Witness' Signature Date

_____

Witness' Printed Name

_____ _____

Notary Date

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MOSQUITO REPELLENT FORM GUIDELINES

This form is mandatory when requesting the use of mosquito repellent for your child. You need to fill this form out and turn it in to your child's teacher. Before doing so, please be sure to follow the following guidelines.

Make sure that your child's mosquito repellent is labeled clearly, and placed in your child's cubby hole.

- Be sure that your child has absolutely no allergies to mosquito repellent, as Our Lady of the Rosary School is NOT responsible for any allergic or medical reactions.

Please put repellent on your child prior to bringing them to school.

---------- Cut here ----------

MOSQUITO REPELLENT PERMISSION FORM

Child's Name _____

Date: _____

Phone Number of Parent/Guardian: _____

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Date_____ _ Time_____ ___ Area_____ ___	Date _____ Time_____ ___ Area _____	Date _____ Time_____ ___ Area_____ ___	Date _____ Time_____ ___ Area _____	Date _____ Time_____ ___ Area _____

Note: Please read the above given guidelines before turning in this form.

_____ _____

Parent/Guardian's signature Teacher Signature

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ONLINE CHILDCARE MONITORING SYSTEM

Child's Name:_____ Classroom: _____

Email Address: _____

Username: (child's last name) _____ Password: _____

Both username & password can be as long or as short as you would like it to be, can include letters and numbers, and any letters should be only lowercase. Password should include no spaces between characters.

Sign Up Date: / _____ / _____ - _____/ _____ / _____

Please Check One:

- Class Package ☐ $20.00/Month
- Class & Cafeteria ☐ $25.00/Month

- Length of Service: ☐ 1 Month ☐ 2 Months ☐ 6 Months ☐ 1 Year ☐ Other: _____

You may sign in to the account by using the username & password you have chosen above. Account will be accessible from up to 3 different computers simultaneously. Please understand that this service is a privilege. If abused, your privileges will be revoked. If you would like to cancel your services, you must inform the front desk with 2 weeks advance notice to avoid being charged for the following month. Also, it is important that you understand that this monitoring system was installed for the parents' and families' benefit, not as a surveillance system.

_____ _____

Parent/Guardian's signature Date

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FOR PARENTS TO FILL OUT AND SIGN:

_____ Application for Elementary School

_____ Emergency Contact / Authorization to Release from OLR School Form

_____ Parental Permission for Release of Records

_____ Anaphylaxis/Allergies Reaction Information from Parent

_____ First Aid and Emergency Medical Care Consent Form

_____ Authorization for an Emergency Treatment

_____ Consent Food Form for School Activities

_____ Permission to Visit St. Catherine of Siena Church

_____ Permission to Photograph and Post

_____ Mosquito Repellent form Guidelines

_____ Online Childcare Monitoring System

FOR PARENTS TO PROVIDE:

_____ Florida Certification Of Immunization

_____ School Entry Health Exam

_____ Birth Certificate

_____ Social Security Card

_____ Parents Identification