

# Our Lady of the Rosary School

10701 SW 95 Street, Miami, FL 33176-2612 305-271-8389  
www.olschoolmiami.com/www.olschool@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

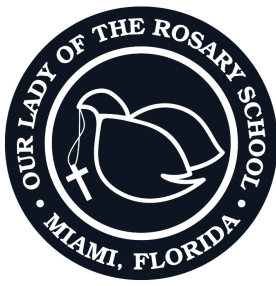
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Social Security# \_\_\_\_\_

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.

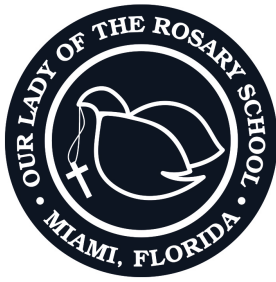
1. Authorized Person: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Phone: \_\_\_\_\_
2. Authorized Person: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Phone: \_\_\_\_\_
3. Authorized Person: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Phone: \_\_\_\_\_
4. Authorized Person: \_\_\_\_\_ Relationship 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? \_\_\_\_\_

o 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)

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

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

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

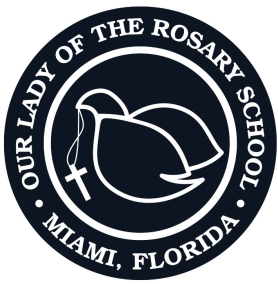
Do you give permission for your child to be released to this person? \_\_\_\_\_ Yes \_\_\_\_\_ No

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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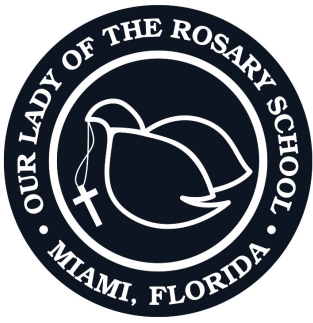
## AUTHORIZATION FOR AN EMERGENCY TREATMENT

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

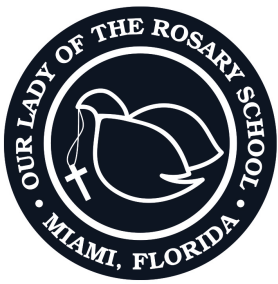
I, \_\_\_\_\_ (parent/guardian printed name), give permission for  
my son/daughter \_\_\_\_\_ (child's name) to eat any food  
given in special occasions and/or school activities.

**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.

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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

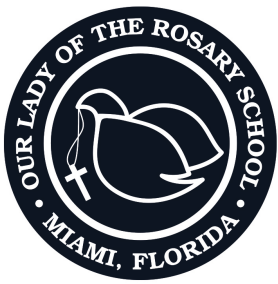
\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
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: \_\_\_\_\_

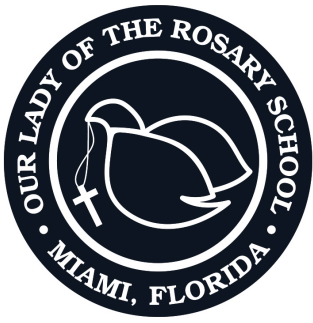
Phone Number of Parent/Guardian: \_\_\_\_\_

<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>
Date _____ —	Date _____ _____	Date _____ _____	Date _____ _____	Date _____ _____
Time _____ _____	Time _____ _____	Time _____ _____	Time _____ _____	Time _____ _____
Area _____ _____	Area _____ _____	Area _____ _____	Area _____ _____	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