After receiving your admissions letter, complete and email the following forms to mwagner@st-bede.com **by July 15 or one month prior to arriving**. Present the original forms to the school office when you arrive at St. Bede. **All medical records MUST be translated into English.**

- **Boarding Application Form**
- **Copy of ID page in Passport**
- **State of Illinois Certificate of Child Health Examination (2 pages)**
- **State of Illinois Eye Examination Report (2 pages)**
- **Required Signatures Form**
- **Screening for Drug Usage Consent Form**
- **Consent to Treat Form**
- **Personal Medical History Form**
- **Official Transcripts (7th grade to current grade)**

After you arrive at St. Bede Academy present the original required forms from above and the following items to the school office.

- **Official Transcripts (7th grade to current grade) / iTEP Scores**

SAINT BEDE ACADEMY

INTERNATIONAL PROGRAM APPLICATION

SAINT BEDE ACADEMY

Application must be typed or printed in English

PROFILE

Surname/Family Name: _____

As it appears on Passport

Given/First Name: _____

As it appears on Passport

Middle Name: _____

As it appears on Passport

Preferred English Name: _____

Age:_____Date of Birth: (Month) _____(Date)_____(Year)_____

Current Grade: _____ Grade Applying: _____

Intake Year:_____Spring/Fall:_____

Gender (Please circle one) MALE FEMALE

Country of Birth: _____

Country of Citizenship: _____ Ethnic Group/Race:_____

Passport Number: _____

Date of Issue:_____ Expiration Date:_____

_____ _____ _____

SAINT BEDE ACADEMY

Home Address:

Street: _____

District: _____City:_____

Province/State:_____Country: _____

Postal Code: _____

Student Email Address: _____

Student Phone Number: _____

Emergency Contact:_____

Emergency Contact Phone Number:_____

FAMILY

Fathers Full Name: _____

Occupation: _____ Title:_____

Employer: _____

Email Address: _____

Phone Number: _____

Address: _____

Mothers Full Name: _____

Occupation: _____ Title:_____

_____ _____ _____

SAINT BEDE ACADEMY

Employer: _____

Email Address: _____

Phone Number: _____

Address: _____

Parents are (please circle one)

Married Divorced Widowed Single

In case of divorce who has legal/residential custody (please circle one)

Father Only Mother Only Legal Guardian

List names, ages, grades and schools of your brothers and sisters

Name:_____Age:_____ Grade: _____

School Name:_____

Name:_____Age:_____ Grade: _____

School Name:_____

List any relatives that have attended St. Bede Academy:

_____

PARENT AND APPLICANT STATEMENT

_____ _____ _____

SAINT BEDE ACADEMY

We, the parents, certify that this applicant is of good moral character. Saint Bede Academy expects him/her to comply with the rules of the school and agree to sustain the Administration in upholding the rules and regulations and in maintaining an atmosphere of good citizenship and courtesy in every aspect of school life.

We, the parents, understand that the academy reserves the right to cancel the registration of any student at any time whatsoever for reasons of deficiency in scholarship, unsatisfactory conduct, or any other just cause.

We, the parents, agree to pay all tuition and fees as set by the Administration.

The applicant agrees to comply with the rules, regulations and requirements of Saint Bede Academy and to cooperate with the administrative officers, faculty and students in maintaining high standards of conduct and scholarship and in promoting the general welfare of the Academy. It is understood that the applicant accepts registration as a student at Saint Bede Academy subject to the above provisions.

By submitting this application you, the parent(s) and the applicant, agree to the above statement and attest that the information requested in this application is complete, honest and accurate to the best of your knowledge and ability.

Signature of Applicant: _____

Signature of Applicant's Parents/Guardian (Under Age 18):

Father_____ Mother _____

Date_____ DD/MM/YYYY

_____ _____ _____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
Age/ Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																				
Hearing																				

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION (**List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No		Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**

Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

SAINT BEDE ACADEMY REQUIRED SIGNATUES FORM

FOR SCHOOL YEAR: 20_____

SAINT BEDE ACADEMY HANDBOOK ACKNOWLEDGMENT

By signing below we acknowledge that we have read the Parent – Student Handbook. We understand that the handbook contains important information about the school, its administration, and about the educational and disciplinary policies and procedures that the school maintains in furtherance of its religious mission. We agree to follow all rules and guidelines imposed in the school by the school administration. By signing below we acknowledge and understand that nothing within this Handbook can be interpreted to create any contractual obligations between the Academy and the student and/or his or her parent(s) and/or guardian(s). By signing below the student and/or his or her parent(s) and/or guardian(s) of the student acknowledge that they read, understand, and agree to abide by the anti-discrimination and anti-harassment policies and the policies regarding alcohol, illegal drug use, and controlled substances. If we have any questions about the content of the handbook, we understand that it is our obligation to ask questions for clarification. This acknowledgment is to be returned to the school after being signed and dated. Failure to read the handbook or to sign or return this acknowledgment shall not relieve us of the obligation to follow all rules and guidelines that the school establishes. Likewise, it will not impede or prevent the school administration from operating the school consistent with those rules and guidelines.

Student Signature **Parent/Guardian Signature** **Date**

SAINT BEDE ACADEMY BOARDING HANDBOOK ACKNOWLEDGMENT

By signing below we acknowledge that we have read, understand and agree to follow the Saint Bede Academy Boarding Program Handbook.

Student Signature **Parent/Guardian Signature** **Date**

SAINT BEDE ACADEMY CHRISTIAN SERVICE PROGRAM HANDBOOK & PERMISSION ACKNOWLEDMENT

By signing below we acknowledge that we have read the Service Program Handbook and understand the purpose, requirements and rules of the program and agree to follow them. We understand that the completion of the Program is a requirement for graduation. Saint Bede Academy assumes no responsibility for accident or injury involving the student or others while participating in a project outside the school hours and not supervised by school personnel. In consideration for my child being allowed to participate in the Academy service program, we hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the Academy, their employees and agents, and the volunteers assisting the school, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorney's fees) arising from or related to my child's participation in this program.

Student Signature **Parent/Guardian Signature** **Date**

STUDENT REQUEST – TEXTBOOK LOAN

The State of Illinois supplies some textbooks. Parents must sign below requesting the use of these books. I hereby request the loan of secular textbooks in accordance with Public Act 79-961 of 1975.

Parent/Guardian Signature **Date**

CO-CURRICULAR AND EXTRA-CURRICULAR ACTIVITIES CONSENT

I hereby give my consent for the above-named student to participate in co-curricular or extra-curricular activities at Saint Bede Academy and to travel with the appointed coach, sponsor or moderator on any school-sanctioned trip.

Parent/Guardian Signature **Date**

STUDENT ACCIDENT INSURANCE & LIABILITY WAIVER

I hereby attest that _____ is covered by accident insurance on a family or group policy. I understand
PRINTED Student Name
that Saint Bede Academy assumes no responsibility for such coverage and that the above-named student will not be permitted to participate in co-curricular or extra-curricular activities unless this attestation is signed and returned to Saint Bede Academy.

In consideration for my student being allowed to participate in co-curricular or extra-curricular activities at Saint Bede Academy I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS Saint Bede Academy and their employees and agents, and the volunteers assisting the school, from any and all liability for injuries, damages, medical expenses, or any other loss to my student or family or me (including attorneys' fees) arising from or related to my student's participation at Saint Bede Academy.

Parent/Guardian Signature **Date**

Parent signs 6 times/Student signs 3 times

SCREENING FOR DRUG USAGE CONSENT FORM REQUIRED OF ALL PARENTS

I/We have read the policy statement regarding the mandatory screening for drug usage that is required of all students in attendance at St. Bede Academy.

I/We understand that the school will request a hair sample of our son/daughter for the purpose of screening and I/we agree that our son/daughter will submit a sample upon request at any time. I/We agree to the methodology being used for hair sampling and sharing the results with appropriate persons referred to in the policy. I/We further agree to defend and indemnify St. Bede Academy, their employees and agents, against any demands or claims of any type whatsoever (including the cost of attorney fees) asserted or based upon any liability arising in any way from or related in any way to the Drug Screening Program, or any acts, errors or omissions relating thereto, by the student identified below whose attendance at St. Bede Academy is conditioned upon the execution of this consent.

I/We understand that failure to comply with this policy in any part or in whole constitutes cause for immediate dismissal from the school.

I/We agree to abide by the terms mandated by this policy if our son/daughter tests positive for the presence of a prohibited substance and will cooperate fully in obtaining an immediate assessment from a substance abuse professional. Furthermore, I/we agree to also cooperate with the particular plan of treatment or recovery that is recommended for our son/daughter.

I/We fully understand that refusal to sign this consent form renders our son/daughter ineligible for attendance at St. Bede Academy.

Printed Name of Student _____

_____ _____

Signature of Parent or Guardian Date

Printed Name of Parent or Guardian _____

SCREENING FOR DRUG USAGE CONSENT FORM REQUIRED OF STUDENTS

I have read the policy statement regarding the mandatory screening for drug usage that is required of all students in attendance at St. Bede Academy.

I understand that the school will request a hair sample from me for the purpose of this screening and I agree that I will submit a sample upon request at any time. I agree to the methodology being used for hair sampling and sharing results with my parents, guardian and/or other appropriate persons referred to in the Policy. I further agree that St. Bede Academy is not responsible if test results are erroneous and hereby release St. Bede Academy, their employees and agents, against any demands or claims of any type whatsoever (including the cost of attorney fees) asserted or based upon any liability arising in any way from or related in any way to the Drug Screening Program, or any acts, errors or omissions relating thereto, by the student identified below whose attendance at St. Bede Academy is conditioned upon execution of the consent.

I understand that failure to comply with this policy in any part or in whole constitutes cause for immediate dismissal for the school.

I agree to abide by the terms mandated by this policy if I test positive for the presence of a prohibited substance and will cooperate fully in obtaining an immediate assessment from a substance abuse professional.

I fully understand that refusal to sign this consent form renders me ineligible for attendance at St. Bede Academy.

_____ _____

Signature of Student Date

SAINT BEDE ACADEMY
MEDICAL – DENTAL – EYE – SURGICAL – EMERGENCY

CONSENT TO TREAT FORM

PRINT IN ENGLISH

Name:_____ Birthdate:_____

I, parent/guardian _____
PARENT'S NAME
hereby voluntarily consent to the rendering of such care, including but not limited to examinations, diagnostic procedures, immunizations, blood transfusions, medical, surgical and emergency care and treatment, by authorized physicians and/or members of the hospital or clinic staff or their designees, as may in their professional judgment be necessary for my child listed above.

I hereby give my consent to SAINT BEDE ACADEMY AND THEIR DESIGNEES who will be caring for my child to arrange for routine or emergency medical/dental/eye examinations, care and treatment necessary to preserve the health of my child.

I acknowledge that no guarantees have been made to me as to the effect of medical/dental/eye examinations, care and treatment.

I acknowledge that I am responsible for all reasonable charges in connection with medical/dental/eye examinations, care and treatment.

I have read this form and certify that I understand its contents.

_____
Parent/Guardian's Signature Date

In case of emergency every effort will be made to contact a parent.

Parent/Guardian's Printed Name in English_____

Relationship to Child:_____

Email Address:_____

Phone Number:_____

Any other information you wish to provide:_____

SAINT BEDE ACADEMY
PERSONAL MEDICAL HISTORY

Name:_____ Birthdate:_____

Date of your last physical:_____ Date of your last tetanus shot:_____

Your current medical condition:_____

List of all prescription or non-prescription medications you are currently taking:_____

List or describe all drug sensitivity and allergies you have:_____

Have you been treated by a physician or hospital during the past year? If yes, describe:_____

Have you had or been advised to have a surgical operation within the last five years? If yes, describe:

Family history – list important medical problems of your parents:_____

Have you ever been told you had or have one of the following? Check yes or no:

	YES	NO
Lung disorder	_____	_____
High blood pressure	_____	_____
Heart trouble	_____	_____
Nervous disorder	_____	_____
Disease or disorder of the digestive tract	_____	_____
Any form of cancer	_____	_____
Disease of the kidney	_____	_____
Diabetes	_____	_____
Arthritis	_____	_____
Hepatitis	_____	_____
Malaria	_____	_____
Disease of disorder of the blood	_____	_____
Any physical defect or deformity	_____	_____
Any vision or hearing disorders	_____	_____
Any life-threatening conditions	_____	_____
Any contagious disorders	_____	_____