Allen County Non Public School Association

HEALTH QUESTIONNAIRE

(Parent/Guardian needs to complete)

Please Print

Student_____Grade_____Date of Birth___/___/___

Address_____

Phone Number_____

Father's name_____Mother's name_____

Student lives with_____

Health History

Check all that apply to your child

ADD/ADHD (circle)
Allergy (specify)
Seasonal _____
Food _____
Other _____
Asthma
Chickenpox
Diabetes

Chronic Ear Infections

Emotional Disorder
GI/GU Issues
Hearing Impairment
Hepatitis
Measles/Mumps/Rubella
Mononucleosis
Physical Handicaps
Pneumonia

Rheumatic Fever

Scarlet Fever
Seizures
Tuberculosis
Vision Impairment
Whooping Cough
____Other_____
____Other_____
____Other
_____
____Other
_____

Any checks made above, please give explanations and dates of diagnosis:

_____

_____

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:

_____

_____

Does your child require the use of an EPI-PEN for allergic reactions?_____

CONTINUED ON REVERSE

(reviewed ACNPSA 1/25)

Please be specific and include the month/year:

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.): _____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures: _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?

_____

_____

_____

Please list any condition that should be considered in planning your child's school day:

_____

_____

_____

Physician's Name: _____ Phone # _____

Dentist's Name: _____ Phone # _____

Eye Doctor's Name _____ Phone # _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

_____ _____

Parent/Guardian signature Date

(reviewed ACNPSA 1/25)

Emergency Information ***ONE PER STUDENT***
ST. LOUIS ACADEMY 2025-26

The information below must be kept on file in the school office. Complete this form for each child and send it back to school. Parents must complete this form prior to the start of the school year. PLEASE PRINT!
Parents are responsible for informing the office during the school year if changes- in emergency information occur.

Name of Child _____ Grade _____ for 2025-26

Name of Parent(s) or Legal Guardian(s) _____

_____ Address _____

Preferred Phone _____ City, State, Zip

Parent Place of Employment_____Work Phone_____

Who should we call if there is an emergency regarding this child, and in what order should we call them?
(This list should include parents & guardians)

Name	Relationship to Child	Phone Number(s)	Type of phone
1.			
2.			
3.			

CONSENT TO EMERGENCY CARE
In the event of an emergency, I request that the school make reasonable attempts to contact me at the above numbers or another parent/adult at the above listed numbers. I understand that in an emergency, difficult circumstances may prevent the school from contacting me immediately or the school may be unable to reach me. I therefore consent to the school taking action which it deems necessary to secure emergency medical care/treatment for my child even if I have not been contacted. I understand that decisions concerning the type of emergency medical care/treatment administered are made by health care providers and/or the school and that demanding circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have for my child which the school may disclose to a health provider. (Check and complete any of the following)

____Dr. _____ is my preferred physician. Phone Number_____
____Dr. _____ is my preferred dentist. Phone Number_____

____My hospital of choice is:_____

____Receipt of my consent prior to my child's receiving major surgery, unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained before surgery is performed. ____If my child's school has a prescription for auto-injectable epinephrine and my child is demonstrating signs or symptoms of life-threatening anaphylaxis during the school day, I DO NOT consent to the administration of auto injectable epinephrine (epi-pen) for my child.

The school may disclose the following checked information to a health care provider:
____Insurance Company: _____ Policy/Group/Claim# _____

____The following information regarding allergies my child has, medication my child is taking, and other medical facts about my child: _____

I understand that in the event of an emergency, the school, will make reasonable efforts to notify a health care provider of the above-checked information; but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

Date: _____ Signature of Parent/Guardian: _____

ADDITIONAL HOUSEHOLD INFORMATION

Child lives with: (Please circle) Full Time Shared Custody

Both Parents Mother Father Stepmother Stepfather Other_____
Any Additional Information:_____

_____

Most Days your child will depart with:_____ I give my permission for the following people to pick my child up from school when needed.

1.	5.
2.	6.
3.	7.
4.	8.

____Yes, I give my child permission to depart from campus to home at dismissal time without adult supervision via walking or riding a bicycle.

____No, I DO NOT give my child permission to depart from campus to home at dismissal time without adult supervision via walking or riding a bicycle.

Parent/ Guardian Signature:_____

Email Address_____ Family Parish_____

If your child attended public school, what elementary or middle school would they attend?

_____

ADDITIONAL MEDICAL INFORMATION

Medication Taken_____ Dosage_____

Time Taken_____ Home or School_____

**If medication needs to be taken at school, a “Consent for Administration of Medication” form must be filled out and filed with the office.

Allergies and / Insect bite information:

_____

_____

Pertinent information regarding child’s physical condition or medications:

_____

_____

Indiana
DEPARTMENT OF EDUCATION

Dr. Jennifer McCormick
Superintendent of Public Instruction

Working Together for Student Success

Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the W-APT will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student**? _____

2. What language(s) is spoken most often by the **student**? _____

3. What language(s) is spoken by the **student** in the home? _____

Student Name:_____ **Grade:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Date:**_____

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name:_____ Date:_____

Internet User Agreement Students in Grades K-8

***ONE PER FAMILY** **(Please read this document carefully before signing.)**

As a user of the St. Louis Academy Catholic School computer network, I hereby agree to comply with the stated rules, terms, and conditions, honoring all relevant laws and restrictions.

I understand that my use of technology and the Internet in the school is a privilege, not a right. Inappropriate use will result in a cancellation of those privileges. The school administration determines appropriate use and their decision is final. Further disciplinary action may follow as indicated in the school handbook.

I understand that I am expected to abide by the generally accepted rules of technology and network etiquette. These include (but are not limited to) the following:

Network and Technology Etiquette

1. Be polite. Do not send abusive messages to others.
2. Use appropriate language. Do not swear, use vulgarities or any other inappropriate language.
3. Illegal activities are strictly forbidden.
4. Keep your personal address and phone number private and do not reveal the phone numbers of students or colleagues.
5. Note that electronic mail (e-mail) is not guaranteed to be private. People who operate the system do have access to all mail. Messages relating to or in support of illegal activities may be reported to the authorities.
6. Use technology and network in such a way that will not disrupt the use of the network by other users.
7. Note that all communications and information accessible via the network should be assumed to be private property.
8. Inform the technology facilitator of any security problem immediately.
9. Inform the technology facilitator of any unsolicited on line contact immediately.
10. Handle with responsibility and care any computers, computer systems, computer networks, iPads, and/or any other school technology made available to you by the school.

I understand that the following are not permitted:

1. Sending or displaying offensive, violent, pornographic, obscene or sexually explicit messages or pictures.
2. Using violent, abusive, obscene or sexually explicit language.
3. Sending harassing, insulting, or threatening messages.
4. Damaging computers, computer systems, computer networks, or iPads or attempting to harm or destroy data of another user.
5. Violating copyright laws.
6. Unauthorized use of another's password.
7. Trespassing in other's folders, work, or files.
8. Intentionally wasting resources.
9. Employing the network for commercial purposes.
10. Transmission of any material in violation of any U.S., state or local law.
11. Obtaining software or data fraudulently or illegally.
12. Revealing one's own or another's personal address or phone number.

Student _____ Student _____

Student _____ Student _____

Student _____ Student _____

Parent/Guardian Signature _____

St. Louis Academy Handbook Receipt Acknowledgment *(P4510)*

All families at St. Louis Academy are required to sign this form and return it to school.

By signing below, we acknowledge that we have received a copy of the St. Louis Academy Student/Parent 2025-2026 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 as part of the Catholic Diocese of Fort Wayne/South Bend.

We agree to follow all rules and guidelines imposed in the school by the school administration and/or the Diocese. 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. However, the failure to read the handbook or to sign or return this acknowledgment shall not relieve us of the obligation to follow all rules and guides that the school and the Diocese establish or in any way impede or prevent the school administration from operating the school consistent with those rules and guidelines.

Each student's parent/legal guardian and all students must acknowledge in writing that they have the handbook and have reviewed its contents with the student.

Family Name printed: _____ Date: _____

Parent Signature: _____

Parent Signature: _____

Student Name Printed:	Student Name Signed:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

St Louis Academy

15529 Lincoln Hwy New Haven, IN 46774 | 260.749.5815 | StlouisAcademy.org

Allen County Non-Public School Association

CHIRP Consent Form

The Indiana State Department of Health maintains an electronic immunization registry entitled Children and Hoosiers Immunization Registry Program (CHIRP). CHIRP allows all health care providers within the state of Indiana to enter and view immunization data with this method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandates that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. We are required to submit these immunization reports to maintain our accreditation. We need your consent via this form to add your child to our school data.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3. I hereby consent to the release of such information.

I, as a parent/legal guardian to the below stated child, give St. Louis Academy permission to release in addition to immunization data, the following information concerning my child to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

_____ _____
Signature Date

_____ _____
Printed Name of Parent(s)/Guardian(s)

_____ _____
Address City, State and Zip Code

_____ _____
Printed Legal Name of Child Birthdate of Child

Grade 2025-2026 _____

PLEASE RETURN AT REGISTRATION OR BEFORE FIRST DAY OF SCHOOL

(revised ACNPSA 9/24)

Send in a copy of your child's immunization record or request a religious exemption form.