

ST. BRIGID/OUR LADY OF HOPE REGIONAL SCHOOL

101 Maple Avenue, Westbury, NY 11590 • (516) 333-0580 • www.stbolh.org



STUDENT INFORMATION

Grade in Sept. 2026 _____

Please print clearly.

Student's

Last Name _____ First Name _____ Middle Name _____

Address _____ Home Phone # _____

Town _____ State _____ Zip Code _____

Student's Date of Birth _____ Please check (✓) one: Male _____ Female _____

Public School District _____

STUDENT'S RACIAL/ETHNIC BACKGROUND-REQUIRED BY FEDERAL GOVERNMENT

Please check (✓) all that apply:

American Indian or Alaskan Native _____ Black _____ Hispanic Black _____

Native Hawaiian/Pacific Islander _____ White _____ Hispanic White _____ Asian _____

Student's

Place of Birth: City _____ State _____ Country _____

Primary Language _____ Languages Spoken at Home _____

School Previously Attended _____

Address _____

Students Religion: _____

If student is **Catholic** – to what parish does he or she belong? _____ Town _____

Baptismal Church _____ Location _____ Date _____

Penance Church _____ Location _____ Date _____

Communion Church _____ Location _____ Date _____

Confirmation Church _____ Location _____ Date _____

FAMILY INFORMATION

Mother's

First & Last Name _____ **Mother's Maiden Name** _____

Mother's Religion _____ **Birthplace** _____ (circle) Living/Deceased

Mother's Occupation _____ **Employer** _____

Mother's Business Address _____

Mother's Home Phone # _____ **Work Phone #** _____ **Cell #** _____

Mother's Work Email _____ **Home Email** _____

Father's First & Last Name _____

Father's Religion _____ **Birthplace** _____ (circle) Living/Deceased

Father's Occupation _____ **Employer** _____

Father's Business Address _____

Father's Home Phone# _____ **Work Phone #** _____ **Cell #** _____

Father's Work Email _____ **Home Email** _____

Child Resides with _____

Who has legal custody _____ **Single Parent Household? Yes** _____ **No** _____

Emergency Contacts (if parents cannot be reached):

1) Name _____ Relationship _____

Home Phone _____ Cell Number _____

2) Name _____ Relationship _____

Home Phone _____ Cell Number _____

3) Name _____ Relationship _____

Home Phone _____ Cell Number _____

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PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE:

Has your child ever been recommended for or received educational testing?

Recommended Yes _____ No _____
Received Yes _____ No _____

If yes, when and why? _____

Has your child ever been recommended for or received counseling?

Recommended Yes _____ No _____
Received Yes _____ No _____

If yes, when, and why? _____

Has your child ever been recommended for or received special education services?

Recommended Yes _____ No _____
Received Yes _____ No _____

If yes, when and why? _____

Grade Nursery & Pre-K Child must be potty trained.

Grade K, 1 & 2 Acceptance into St. Brigid/Our Lady of Hope Regional School depends on passing the **School Readiness Test** and other educational evaluations.

Grades 3 –8 Acceptance into St. Brigid/Our Lady of Hope Regional School depends on **conduct report, school grades, and results of any standardized testing or other educational evaluations.**

I have read, understand, and agree to abide by the **Technology Use Policy, Code of Conduct, Photo/Video Release, and the Mobile Device Policy**, the text of which can be found on our website under the **Handbook tab**.

I have answered these questions to the best of my knowledge.

Parent/Guardian Signature

Date

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RECORD RELEASE

Dear Parents/Guardians,

Please complete the information below, which will authorize release of your child's records to St. Brigid/Our Lady of Hope Regional School. After you complete this form, please return it along with your completed Registration Forms and Fees to our Business Office.

My Child's Current School and Address (please print):

School Name: _____

Address: _____

Dear Principal,

As parent/guardian of _____ currently in Grade _____
(Please print)

I authorize you to:

- Release all appropriate information concerning his/her academic (including standardized test scores and educational testing), personal, and medical records
- Speak to my child's former teachers, guidance counselor, principal, and/or Health Office staff to gather a better understanding of my child's academic progress

I understand this information will be used in connection with St. Brigid/Our Lady of Hope Regional School and will be held in strict confidence.

Parent/Guardian's Signature

Date

Please send all records to:

Business Office

St. Brigid/Our Lady of Hope Regional School

101 Maple Avenue

Westbury, NY 11590

St. Brigid/Our Lady of Hope Regional School admits students of any and all races and affords all students, regardless of race, all rights, privileges, and opportunities to participate in all programs and activities generally afforded and made available to students at the School. The School does not discriminate on the basis of race in the administration of its education policies, scholarship and loan programs, and athletic and other School-administered programs.

FACTS Tuition Registration Form 2026-2027

Family Name _____

Student name: _____ Gr. _____ Student name: _____ Gr. _____

Student name: _____ Gr. _____ Student name: _____ Gr. _____

Nursery and Pre-K only Please check one: 3 Mornings _____ 5 Mornings _____ 3 Full Days _____ 5 Full Days _____

Toddler Only: Tuesday _____ **Toddler PLUS:** Tuesday AND Thursday _____

I agree to pay fees for the 2026-27 school year. I understand that the Participation Fee and Big Bucks fundraiser will be paid in accordance with my tuition. I also agree to register online within 48 hours with FACTS directly.

OPTION #1 - IN FULL PAYMENT

- One payment, in full, will be **automatically withdrawn from your bank account by FACTS on August 1, 2026.**
- With this plan all fees are included.
- If funds are not available a charge of \$30.00 will be added to your account.
- If payment is not received by August 5th, you will be put on the monthly plan (July plus late fees will be due).

I have read, understand and agree to abide by the **Technology Use Policy, Code of Conduct, Photo/Video Release, and the Mobile Device Policy, the text of which can be found on our website under the Handbook tab.**

I also understand that my child(ren) will automatically be re-enrolled each year and registration fees will automatically be deducted from my FACTS account each February unless written notice is given to the Business Office.

Full Payment Signature: _____ Date: _____

OPTION #2 - MONTHLY PAYMENT

- Monthly installments beginning in July 2026.
- **Automatic bank payments will be processed on the 5th or 20th of each month.** If funds are not available on date selected, a \$30.00 fee will be added to your account.
- Payments are paid **directly to FACTS** each month.
- With this plan all fees are included.

I have read, understand, and agree to abide by the **Technology Use Policy, Code of Conduct, Photo/Video Release, and the Mobile Device Policy, the text of which can be found on our website under the Handbook tab.**

I also understand that my child(ren) will automatically be re-enrolled each year and registration fees will automatically be deducted from my FACTS account each February unless written notice is given to the Business Office.

Monthly Payment Signature _____ Date: _____

CASH PAYMENTS WILL NOT BE ACCEPTED AT THE SCHOOL (Except for the registration fees)

Checks returned for insufficient funds are subject to a \$25.00 bank fee.

For Office Use Only

Date _____	Reg Fees left _____	Tuition _____	PS _____	FACTS _____	Excel _____
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St. Brigid/Our Lady of Hope Regional School may use your child's photographic likeness and/or voice in all forms for use on the school's official website, school's official Facebook page, and electronic and/or paper publications. St. Brigid/Our Lady of Hope Regional School is released from all liability arising from such use, and no compensation will be paid for such use.

FACTS TUITION MANAGEMENT

IMPORTANT INFORMATION

FACTS Management Company helps us manage our tuition payment program.

1st Time Enrollees:

All new families **MUST** register with FACTS online within **48 hours of registration** AND complete and sign the FACTS Tuition Registration Form.

- Please go to our homepage: www.stbolh.org and click on the ADMISSONS tab at the top and then the FACTS Tuition Management link.
- Create a username and password to activate your account.
- Click “Set Up Payment Plan” and follow the instructions.

If you cannot register within 48 hours contact the school office immediately at (516) 333-0580.

PAYMENT OPTIONS:

Option #1

Pay in full to FACTS by August 1, 2026.

Please complete and sign the enclosed registration form where indicated. Return to our office along with the registration fees and your Donation Report Form from the church. Note, you will be charged a re-enrollment fee in February for the following school year.

Option #2

Pay the tuition in 10 monthly installments to FACTS. Payments begin in July 2026 and end in May 2027. Tuition will not be collected in February because of re-enrollment fees for the following school year.

Please complete and sign the enclosed registration form where indicated. Return to our office along with the registration fees and your Donation Report Form from the church.

*****If you register late your monthly payments will be adjusted accordingly and payments will be higher. *****

No credit checks or interest charges are associated with enrollment in FACTS. Payments are charged to your credit card or deducted automatically from your bank account.

Questions about the FACTS program can be directed to FACTS at 1-800-624-7092 or the school office.

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HEALTH DOCUMENT REQUIREMENTS

The New York State Education Law requires all students to have a medical examination upon original entry into school and routinely at grades Pre-K, Kindergarten, 1,3,5 and 7.

- **New students** must have all medical forms completed with results and forms signed by a New York State physician submitted before the first day of school. Medical forms must be dated after September 1, 2024.
- **All Students entering Toddler, Toddler Plus, Nursery, Pre-K, Kindergarten and Grades 1, 3, 5, and 7** must have completed and signed medical forms before classes begin in September or your child will not be permitted to attend class on the first day of school.

Grade 7 must have proof of meningitis and Tdap vaccine.

Grade 6 must have proof of Tdap vaccine.

MEDICATION:

Should your child need to take medication in school, the attached Medication Form must be filled out and signed by your child's doctor. Medication will be kept in the Health Office, with the exception of middle school students who have a medical note for self carry.

ATTACHMENTS:

1. School Health Form
2. Medication Form

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MEDICATION IN SCHOOL

According to the New York State Law, the only way medication can be given during school hours is if the school nurse receives a doctor's note stating the name of the medication, the dosage, the time to be given, and a note from the parent giving the school nurse permission to give the medication. This signed form is to be used for all over-the-counter and prescription medication.

Please do not have medication in school for a child to take on his/her own. We have many children who are allergic to various drugs. If these should unknowingly fall into their hands, the results could be fatal.

MEDICATION FORM

To the PHYSICIAN: (please complete)

Child's Name _____

Medication _____

Dosage _____

Time to be given _____

Physician's Signature _____

To the PARENT: (please complete)

I give my permission to the School Nurse to administer the medication as prescribed above by my doctor for my child.

Parent Signature _____

If you have any questions, please feel free to contact the School Nurse. Thank You.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name: _____ Sex: ☐ M ☐ F DOB: _____
School: _____ Grade: _____ Exam Date: _____

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and >

Hypertension: ☐ No ☐ Yes

Hypertension: ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	☐ Mental Health: _____
☐ Test Done ☐ Lead Elevated ≥ 10 $\mu\text{g/dL}$				☐ Other: _____

☐ System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations: _____ Diagnoses/Problems (list) _____ ICD-10 Code _____

☐ Additional Information Attached

Name:

DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
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Distance Acuity	20/	20/	☐ Yes ☐ No	
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Distance Acuity With Lenses	20/	20/		
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Vision – Near Vision	20/	20/		
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Vision – Color	☐ Pass ☐ Fail			
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Hearing

Right dB

Left dB

Referral

Pure Tone Screening

☐ Yes ☐ No

Scoliosis Required for boys grade 9

Negative

Positive

Referral

And girls grades 5 & 7

☐☐☐ Yes ☐ No

Deviation Degree:

Trunk Rotation Angle:

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ Full Activity without restrictions including Physical Education and Athletics.☐ Restrictions/Adaptations

Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ No Contact Sports

Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ No Non-Contact Sports

Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ Other Restrictions:☐ Developmental Stage for Athletic Placement Process ONLY

Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports

Student is at Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V☐ Accommodations: Use additional space below to explain☐ Brace*/Orthotic☐ Colostomy Appliance*☐ Hearing Aids☐ Insulin Pump/Insulin Sensor*☐ Medical/Prosthetic Device*☐ Pacemaker/Defibrillator*☐ Protective Equipment☐ Sport Safety Goggles☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ Order Form for Medication(s) Needed at School attached

List medications taken at home:

IMMUNIZATIONS

☐ Record Attached☐ Reported in NYSISReceived Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:

Date:

Provider Name: (please print)

Stamp:

Provider Address:

Phone:

Fax:

Please Return This Form To Your Child's School When Entirely Completed.

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the ["ACIP-Recommended Child and Adolescent Immunization Schedule."](#) Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³		Not applicable	1 dose given after age 10 years	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart and between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		



Department
of Health