



St. Joseph Preschool

To Learn!! To Grow!! To Make a Difference!!

St. Joseph School
 825 Second Street Verona, PA 15147
 Main Office – 412-828-7213 Preschool Office – 412-828-7213 ext 2
 FAX: 412-828-4008 EMAIL: stjosephelementary@comcast.net



Please check program of interest:

- Three Year Old Program - Monday, Wednesday, Friday - 8:30 AM – 11:30 AM (\$1,900)
- Three Year Old Program -Tuesdays and Thursdays - 8:30 AM – 11:30 AM (\$1,300)
- Four Year Old Half Day Program - Monday, Wednesday, Friday - 8:30 AM – 11:30 AM (\$1,900)
- Four Year Old Half Day Program - Monday Through Friday - 8:30 AM – 11:30 AM (\$2,500)
- Four Year Old All Day Program – Monday Through Friday - 8:30 AM – 2:30 PM (\$3,900)

STUDENT DATA *(Please Print Clearly)*

Student's Last Name:		First:	Middle:
Address:			Male / Female:
City:	State:	Zip:	Phone:
Date of Birth:		Age as of September 1:	
Public School District of Residence (Taxes paid to):			
Religion:		If Catholic, parish and diocese:	
Ethnicity: <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian <input type="checkbox"/> Multi-racial <input type="checkbox"/> Pacific Island <input type="checkbox"/> Other			

FAMILY DATA *(Please Print Clearly)*

MOTHER (First, Maiden & Last)	FATHER
Name:	Name:
Address:	Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Emergency Phone:	Emergency Phone:
E-mail:	E-mail:
Occupation:	Occupation:
Employer:	Employer:
Business Phone:	Business Phone:
Religion:	Religion:
Parish where registered:	Parish where registered:

Student resides with: Both Parents Mother only Father only Joint Custody Other

Parents/Guardians Marital Status: Married Separated Divorced Widowed Single Parent

Please list any talents or interests you will be willing to share with the school _____

For office use only:

Immunization Registration Fee

GUARDIANSHIP (if applicable)

Custody: A legal document stating guardianship must be provided in cases of divorce with sole and/ or shared custody

Student's legal guardian (if other than parent) _____

Relationship to the student _____

Mail will be sent to student's address. How do you wish correspondence from the school to be addressed?

(Examples: Mr. and Mrs. John Miller; Ms. Veronica Smith; Mr. John Smith; Mrs Veronica Smith)

If mail is to be sent to a second address, please advise.

BROTHERS / SISTERS IN ORDER OF BIRTH:

Name	Male/Female	Date of Birth
1.		
2.		
3.		
4.		

In order to provide the best education for your child, please complete the following:

Has your child ever:

1. **Been diagnosed with any of the following:**

LD (Learning Disability) ADD (Attention Deficit Disorder) ADHD (Attention Deficit Hyperactive Disorder) ASD (Autism Spectrum Disorder) ODD (Oppositional Defiant Disorder) Other

Does your child take medication associated with this diagnosis? Yes No

If yes, please specify. _____

2. **Had an IEP?** Yes No If yes, what is the disability? _____

Please submit a copy of the IEP.

3. **Been diagnosed with a medical condition that the school should be aware of?** Yes No

If yes, please explain _____

Parent/Guardian Signature _____

Date _____

Please return this Application Packet with a non-refundable fee of **\$25.00**. Checks and money orders should be made payable to **St. Joseph School**.

In order for a student to be accepted and registration finalized, all documentation as noted on the bottom of the first page must be submitted.

New students are accepted on a probationary basis. New students and their families should be cognizant of, and willing to comply with, all school expectations. If problems arise during the probationary period, which have not been resolved, the student will be required to transfer.