January 27, 2015

Dear CCHRS Parents:

Please find attached the re-registration materials for Corpus Christi Holy Rosary School for the 2015–2016 academic year. As in the past, we have done our best to keep our tuition affordable, although it is inevitable that it must go up each year as salaries, benefits, utilities, etc… rise.

Please complete all information on the enclosed forms and return in the original envelope to the office by February 28th.

Please note the early registration fee of $50 per child for re-registration by February 28th. Re-registrations submitted after February 28th must pay the full $100 per child registration fee.

All current fees and payments must be up-to-date in order for us to process your child(ren’s) re-registration. Should there be any particular situations, please see me about them.

There are limited funds available for tuition assistance for current students going into Grades K – 8. On February 15th, the Tuition Assistance forms will be available upon request for families registered for the 2015-2016 school year. These forms must be submitted by March 31st with documentation (including an IRS 1040) for consideration of Tuition Assistance. Incomplete forms cannot be processed and will be returned to you.

Thank you for the sacrifices you make to give the valuable gift of a Catholic education to your child(ren) and for your support in making our community at Corpus Christi Holy Rosary School a center of strength and support for our families!

God bless you. Keeping you and all your loved ones in prayer,

Sr. Theresa Lee, FMA
Principal

(For your convenience, this document is arranged for two-sided printing)
2015-2016 REGISTRATION

Father: First and Last Name

Mother: First and Last Name

Student: First and Last Name

Date of Birth

Grade – Sept. 2015

Name/Town of Church

Envelop # (if applicable)

Tuition and Fees

<table>
<thead>
<tr>
<th>Parishioner Tuition</th>
<th>Non-Parishioner Tuition</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Child $4,900</td>
<td>One Child $6,500</td>
</tr>
<tr>
<td>Two Children $8,400</td>
<td>Two Children $11,000</td>
</tr>
<tr>
<td>Three Children $11,700</td>
<td>Three Children $13,000</td>
</tr>
<tr>
<td>PK –only $7,300</td>
<td>PK –only $8,200</td>
</tr>
<tr>
<td>PK –siblings $6,300</td>
<td>PK –siblings $7,850</td>
</tr>
</tbody>
</table>

Tuition payments are due in ten monthly payments. First tuition due date: August 15, 2015

ALL fees are due June 15, 2015.

Parent: ____________________________  Date Signed: __________________________

Parent’s signature indicates your agreement to pay tuition and all fees on the due dates.

Books/Materials Fees include Student Accident Insurance; Standardized Testing Program; all text books; workbooks; instructional materials; duplicated papers; Library supplies; some art supplies; start-up and use fees of the updated Student Information Services required by the Archdiocese of NY for student records, report cards, and other mandated items. During the summer or on the last day of school, parents will receive a Supply List for items that children should bring to school on the first day.

(01-2015)
<table>
<thead>
<tr>
<th>FEE</th>
<th>AMOUNT</th>
<th>DATE PAID</th>
<th>BALANCE DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLICATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REGISTRATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOOKS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TECHNOLOGY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NJ/CT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**CORPUS CHRISTI HOLY ROSARY SCHOOL**  
**HEALTH CERTIFICATE / APPRAISAL FORM**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School:</th>
<th>Gender: M F</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached
- No immunizations given today
- Immunizations given since last Health Appraisal:
  - Sickle Cell Screen: 
    - Positive
    - Negative
    - Not done
    - Date: _______________
  - PPD: 
    - Positive
    - Negative
    - Not done
    - Date: _______________
  - Elevated Lead: 
    - Yes
    - No
    - Not done
    - Date: _______________
  - Dental Referral: 
    - Yes
    - No
    - Not done
    - **Significant**

### Medical/Surgical History:
- See attached

### Allergies:
- LIFE THREATENING
- Food: _______________
- Insect: _______________
- Other: _______________
- Seasonal
- Medication: _______________

### PHYSICAL EXAM

- Height: _______________
- Weight: _______________
- Blood Pressure: _______________
- Date of Exam: _______________

#### Referral

- **Body Mass Index:** _______ _______ · _______
- **Weight Status Category (BMI Percentile):**
  - less than 5th
  - 5th through 49th
  - 50th through 84th
  - 85th through 94th
  - 95th through 98th
  - 99th and higher
- **Vision - without glasses/contact lenses**
  - R
  - L
- **Vision - with glasses/contact lenses**
  - R
  - L
- **Vision - Near Point**
  - R
  - L
- **Hearing** Pass 20 dB sc both ears or:
  - R
  - L

#### EXAM ENTIRELY NORMAL

- **Tanner:** I. II. III. IV. V.  
- **Scoliosis:** 
  - Negative
  - Positive

- Specify any abnormality (use reverse of form if needed):

### MEDICATIONS

- Medications (list all):
  - None
  - Additional medications listed on reverse of form

<table>
<thead>
<tr>
<th>Name:</th>
<th>Dosage/Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Dosage/Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If AM dose is missed at home:

- I assess this student to be self-directed
  - Yes
  - No

- Student may self-carry and self-administer medication
  - Yes
  - No

- Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION (WHERE APPROPRIATE) / CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
  - Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
  - Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

- Specify medical accommodations needed for school:
  - None

- Known or suspected disability:
  - Please monitor

- Restrictions:
  - Please monitor

- Protective equipment required:
  - Athletic Cup
  - Sport goggles/impact resistant eyewear
  - Other: _______________

### OPTIONAL INFORMATION, if known

- Specify current diseases:
  - Asthma
  - Diabetes: Type 1
  - Type 2
  - Hyperlipidemia
  - Hypertension

- Other: _______________

<table>
<thead>
<tr>
<th>Provider’s Name/Address:</th>
<th>Phone:</th>
<th>Fax:</th>
<th>(Stamp below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Parent/Guardian,

New York State Law Section 2164 and Port Chester Union Free School District requires certain immunizations to enter 6th grade and attend school. Please check with your Health Care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below:

- **Varicella** (chickenpox)
  2 doses – a health care provider’s signed medical record indicating the student had varicella disease is acceptable proof of immunity.

- **Polio**
  3-4 doses

- **Hepatitis B**
  3 doses

- **DTP/DTaP/Tdap**
  3 doses

- **Tdap**

- **MMR**
  2 doses

If you have questions or concerns about immunizations, please contact the school nurse.
# TUBERCULOSIS RISK ASSESSMENT QUESTIONNAIRE

*(TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY)*

**PATIENT’S NAME**

<table>
<thead>
<tr>
<th>DOB:</th>
<th>DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Has the student recently emigrated from a country with a high incidence of tuberculosis?  
*Includes most countries from Asia, Africa, Eastern Europe, Central and South America*  
**YES** ☐ **NO** ☐

2. Did the student travel to a high-incidence country for more than one month?  
*(e.g., where housing was with family members or local residents; not hotels, resorts, etc.)*  
**YES** ☐ **NO** ☐

3. Did the student have household contact with parents or others who immigrated or visited from a country with a high incidence of tuberculosis and tuberculin status unknown?  
*(Include: immediate and extended family, overnight guests, frequent visitors, and babysitters.)*  
**YES** ☐ **NO** ☐

4. Did the student have exposure to individuals in the past 5 years who are HIV infected, homeless, institutionalized, users of illicit drugs, incarcerated, or have known tuberculosis disease?  
*(Test all groups every 2-3 years)*  
**YES** ☐ **NO** ☐

5. Does the student have HIV infection (test yearly), diabetes mellitus, chronic renal failure, malnutrition, reticuloendothelial disease, other immunodeficiencies or receiving immunosuppressive therapy?  
**YES** ☐ **NO** ☐

6. Has someone from a high risk country spent more than one month in the home of a student?  
**YES** ☐ **NO** ☐

**IF YES has been answered to any of the above questions, a tuberculosis skin test is indicated.**

**TB TESTING RECOMMENDED?**

<table>
<thead>
<tr>
<th>NO</th>
<th>Patient has no risk factors and active tuberculosis is NOT suspected</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>DATE PPD ADMINISTERED</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF THE TST IS POSITIVE, NOW OR PREVIOUSLY, THE FOLLOWING ARE REQUIRED**

<table>
<thead>
<tr>
<th>DATE OF POSITIVE PPD</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEST X-RAY</td>
<td>DETAILS</td>
</tr>
<tr>
<td>☐ NORMAL</td>
<td>DETAILS</td>
</tr>
<tr>
<td>☐ ABNORMAL (describe)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLINICAL EVALUATION</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ NORMAL</td>
<td>DETAILS</td>
</tr>
<tr>
<td>☐ ABNORMAL (describe)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ DEFERRED (describe)</td>
<td></td>
</tr>
<tr>
<td>☐ INITIATED (describe)</td>
<td></td>
</tr>
</tbody>
</table>

**HEALTH CARE PROVIDER SIGNATURE AND STAMP**

<table>
<thead>
<tr>
<th>DATE</th>
</tr>
</thead>
</table>
# Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school’s medical director or school nurse as soon as possible.

## Section 1. To be completed by Parent or Guardian (Please Print)

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

**Birth Date:** / /  
Month Day Year  
Sex: ☐ Male  ☐ Female

Will this be your child’s first oral health assessment? ☐ Yes ☐ No

School: Name  
Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment, I understand this assessment is only a limited means of evaluation to assess the student’s dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent’s Signature:  
Date

## Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of ______________________________ on__________ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student’s ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist’s/ Dental Hygienist’s name and address**  
(please print or stamp)  
**Dentist’s/Dental Hygienist’s Signature**

Optional Sections - If you agree to release this information to your child’s school, please initial here.

II. Oral Health Status (check all that apply).

☐ Yes ☐ No  **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No  **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No  **Dental Sealants Present**

Other problems ( Specify): __________________________________________________________________________

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.
TO BE COMPLETED BY PARENTS:

PUPIL HEALTH INFORMATION

STUDENT’S NAME __________________________________________ SEX: M___F___ GRADE _____

LAST FIRST MIDDLE

ADDRESS __________________________________________ TELEPHONE ______________________

DATE OF BIRTH ______________________ PLACE OF BIRTH_____________________________________

FATHER’S/GUARDIAN’S NAME ______________________________ CELL # __________________________

MOTHER’S/GUARDIAN’S NAME ______________________________ CELL # __________________________

EMERGENCY CONTACT NAME ___________________________ CELL # __________________________

NAME OF STUDENT’S PHYSICIAN ______________________ TELEPHONE # ______________________

PLEASE INDICATE BELOW (YES OR NO) ANY OF THE FOLLOWING HEALTH PROBLEMS. IF YES, GIVE APPROXIMATE DATE.

<table>
<thead>
<tr>
<th>ALLERGIES (PLEASE SPECIFY)</th>
<th>SERIOUS INJURIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASTHMA</td>
<td>SEIZURE DISORDER</td>
</tr>
<tr>
<td>DIABETES</td>
<td>SPEECH PROBLEM</td>
</tr>
<tr>
<td>CURRENT MEDICATION</td>
<td>SURGERY</td>
</tr>
<tr>
<td>FRACTURES</td>
<td>VISUAL LOSS</td>
</tr>
<tr>
<td>HEARING LOSS</td>
<td>OTHER</td>
</tr>
<tr>
<td>HEART CONDITION</td>
<td></td>
</tr>
</tbody>
</table>

_________ MY SON/DAUGHTER IS ABLE TO PARTICIPATE IN ALL PHYSICAL EDUCATION AND CO-CURRICULAR ACTIVITIES.

_________ MY SON/DAUGHTER IS NOT ABLE TO PARTICIPATE IN ALL PHYSICAL EDUCATION AND CO-CURRICULAR ACTIVITIES DUE TO ____________________________.

I UNDERSTAND A MEDICAL CERTIFICATE WILL BE REQUIRED FROM MY PHYSICIAN OR HEALTH FACILITY REGARDING THIS PROBLEM.

DATE ___________________ PARENT’S SIGNATURE ________________________________
**Child’s Information**

Name _________________________________

  Last                                          First                                          Middle

Date of Birth ______________________________

Address ____________________________________  City__________________  State___  Apt#____  Zip__________

Phone ___________________  Cell # ___________________

Gender ________    Religion    _________________________

Parish __________________________

**Sacrament**

<table>
<thead>
<tr>
<th>Sacrament</th>
<th>Date</th>
<th>Church</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baptism (certificate required)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reconciliation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>First Holy Communion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Confirmation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child resides with ____________________________________________  Relationship ________________________________

**Mother’s Information**

Please circle: Single  Married  Separated  Divorced  Deceased

Name _________________________________________________

  Last                                          First                                          Middle

Address ____________________________________  City__________________  State___  Apt#____  Zip__________

Religion ___________________________ Occupation __________________________

Business Address _____________________________________  Email __________________________  Phone ___________  Cell#___________

**Father’s Information**

Please circle: Single  Married  Separated  Divorced  Deceased

Name _________________________________________________

  Last                                          First                                          Middle

Address ____________________________________  City__________________  State___  Apt#____  Zip__________

Religion ___________________________ Occupation __________________________

Business Address _____________________________________  Email __________________________  Phone ___________  Cell#___________
Custody of Child (if applicable)

<table>
<thead>
<tr>
<th>Custodial Parent</th>
<th>Relationship</th>
<th>Documentation</th>
<th>Date provided</th>
</tr>
</thead>
</table>

Guardianship of Child (if applicable)

<table>
<thead>
<tr>
<th>Guardian</th>
<th>Relationship</th>
<th>Documentation</th>
<th>Date provided</th>
</tr>
</thead>
</table>

Child’s Education

<table>
<thead>
<tr>
<th>Previous schools attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
</tbody>
</table>

Child has been evaluated by the district Committee on Special Education. ____ Yes _____ No
Child has been evaluated by a private psychological or educational agency. _____ Yes _____ No

If answer to either or both statements above is YES, applicant must complete the following:

<table>
<thead>
<tr>
<th>Type of Evaluation</th>
<th>Date of Evaluation</th>
<th>Name of Agency</th>
<th>Contact Name and Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If child has been seen by the public district Committee on Special Education, applicant must complete the following:

1. Was an IEP ever generated? ____ Yes ____ No Copy Submitted _______________
2. Child has a Section 504 Accommodation Plan. ____ Yes ____ No Copy Submitted _______________

Date _______________

<table>
<thead>
<tr>
<th>District Name and #</th>
<th>Date of most recent IEP</th>
<th>Date of Last Psychological Evaluation</th>
<th>Classification and Recommended Placement</th>
</tr>
</thead>
</table>

I affirm that the above information is true to the best of my knowledge. I understand that failure to provide the required documentation stops the application process. Furthermore, should my child be accepted/admitted under false, incomplete or negligent information, my child will be dismissed from the school. I also agree that should my child be accepted/admitted, my child and I will be bound by the terms and conditions of the school’s parent/student handbook including those provisions referencing inoculations. Final acceptance is also dependent on all fees being paid in full to previous school. Acceptance notices will be mailed.

Signature of Parent or Guardian ___________________________ Date: ___________________
Corpus Christi Holy Rosary School is dedicated to the education of the whole child. Through collaboration based on the ideals, practices, and the Gospel message of hope, Corpus Christi Holy Rosary School parents, faculty, staff, and administrators strive to enable students to respond with faith to the many challenges of society. Your family’s witness in living Christian values, liturgical worship, and the sacramental life is fundamental to this effort and the total Christian formation of your child.

The following information is requested of each family applying for admission to Corpus Christi Holy Rosary School.

1. Are you Catholic?______________  (If YES, please answer question #2)

2. Will you and your family attend Mass regularly?_______________

3. If non-Catholic, do you attend your own Church?______________
   Church name and address: ___________________________________________

4. Will you SUPPORT the rules and policies of Corpus Christi Holy Rosary School?__________

5. Will you ATTEND all PTO (parent-teacher meetings) and parent-teacher conferences as they are scheduled during the year? ________________

6. Will you CONTRIBUTE at least 16 Service Units to the school during the year?_______
   (13 service units for single parent families)

7. Will you ACTIVELY FULFILL ALL the requirements of fund-raising activities of CCHRBS such as chocolate sales and other? ________________

8. Will you COMMIT yourself to meet your financial obligations to the school on time? THIS IS A SERIOUS COMMITMENT. Failure to do so will result in the suspension of educational services for your child/children until the outstanding balance has been satisfied. ________________

Please share: Why do you want your child/ren to attend Corpus Christi Holy Rosary School?

________________________________________________________________________

________________________________________________________________________

I have read all of the above and commit to all of the above.

_________________________________________________________  __________
Parent/Guardian Signature                        Date

(01-2015 revised)  (Over)
This agreement for SERVICE UNITS applies to every family – parishioner and non-parishioner. All families need to earn a minimum of 16 service units. 1 unit = 2 volunteer hours. Single parent families need to earn the minimum of 13 units.

Name of Child One: ___________________________________ Grade_________
Name of Child Two: ___________________________________ Grade_________
Name of Child Three: ___________________________________ Grade_________

Parent’s Last Name: ____________________________________________

Please initial next to the option of your choice.

OPTION ONE________________
I agree to earn at least 16 service units through fundraising activities and/or volunteer hours. (13 for single parent families). I understand that it is my responsibility to acquire at least half of my units to re-register for the next school year. If I do not reach my quota of UNITS I will pay the equivalent of $20.00 per UNIT missing. This payment will be due by June 1st 2016. I understand that fundraising and volunteering helps keep down tuition costs and is part of my obligation in sending my child/ren to Corpus Christi Holy Rosary School.

OPTION TWO________________
I agree to pay $320 for my units by November 21, 2015 in lieu of participating in fundraising and volunteering activities. However, I may still choose to volunteer during the school year in various PTO and school activities. I understand that helping with the fundraising efforts of the school helps keep down tuition costs and is part of my obligation in sending my child/ren to Corpus Christi Holy Rosary School.

Please print your name

Signature

Date

(01-2015)
NEW YORK STATE RESIDENTS ONLY
Grades K to 8
REQUEST FOR LOAN OF TEXTBOOK

Please complete one form for each student.

Dear Principal:

Under the provisions of section 701, Subdivision 2 of the Education Law of the State of New York, I request that my local Board of Education provides textbook funding for my child attending Corpus Christi Holy Rosary School.

My local school district is ____________________________________________
(example: Port Chester-Rye Brook, etc.)

Student: __________________________________________________________
Grade: __________________________________________________________

____________________________________ ______________________
Parent/Guardian Signature Date