



THE URSULINE SCHOOL

STUDENT ENROLLMENT CONTRACT

1354 North Avenue | New Rochelle, NY 10804 | Telephone: 914.636.3950 | Fax: 914.636.3949 | www.ursulinenewrochelle.org

Student's name _____ Grade _____
Last First Middle

The cost of tuition for the 2023–2024 academic year is \$21,575. A non-refundable deposit of \$2,000 is due March 1, 2023 to ensure your place at The Ursuline School. This non-refundable deposit will be applied toward the total tuition. In mid-June, invoices will be sent from the Finance Office. This invoice will reflect your paid deposit, and any additional payments made to date, as well as any scholarships or grants that your daughter was awarded with her offer of admission.

After initial deposit, please indicate your payment options for the remaining tuition:

- ☐ Paid in Full: 1 payment, due July 1, 2023. If paying in full by cash or check, a \$300 discount* may be applied if payment is received on or before July 31, 2023 (*not applicable to families receiving financial aid.)
- ☐ Semi-Annual: 2 payments, due July 1, 2023, and December 1, 2023.
- ☐ Quarterly: 4 payments, due July 1, 2023, September 1, 2023, November 1, 2023, and January 1, 2024.
- ☐ School Year: 10 payments, due July 1, 2023, through April 1, 2024.

There are two remittance options:

- ☐ Check
- ☐ ACH (Automatic debit of checking account - preferred method of payment) See reverse side.

☐ **ACH method**

Please use the bank routing number and account number from my enclosed deposit check.

I authorize The Ursuline School to initiate withdrawals from my account

_____ for payment of tuition for the 2023 – 2024 academic year.

Bank Name

Routing number

Account Number

I understand a withdrawal will be made on the 1st day of the month or the next business day in the amount of my tuition. These withdrawals may be made electronically and under the Rules of the National Automated Clearing House Association.

Authorized Account Holder Signature _____ Date _____

Joint Account Holder Signature _____ Date _____

The Ursuline School is registered with Your Tuition Solution, an Education Loan company. Contact them if you need to setup a more tailored payment plan. <https://secure.yourtutionsolution.com>

Sibling Discount:

If more than one daughter is enrolled at The Ursuline School, the older daughter will receive a 10% discount off the current year tuition.

TERMS OF ENROLLMENT CONTRACT

Student's Full Name

Grade

Date

1. This agreement is made with the understanding that I have read and accept the terms and conditions set forth in this Enrollment Contract.
2. I understand that I am legally responsible for the payment of all tuition and fees. In the event The Ursuline School must take legal action to recover funds, I fully understand, in addition to the unpaid tuition, fees and late fees, that I am fully responsible for all expenses and cost of such action, including costs, disbursements and reasonable attorneys' fees.
3. I understand the deposit is non-refundable if my daughter does not attend The Ursuline School.
4. I understand that all Tuition and fees MUST be current to be eligible for re-enrollment for the next calendar school year.
5. Failure to maintain tuition payments in accordance with your selected payment option can result in suspension from classes or exams. In addition, Tuition payments must be current in order to:
 - Receive a class schedule at the beginning of the School Year
 - Take mid-term and/or final exams
 - Participate in team sports
 - Participate in field trips within the USA or abroad
 - Attend Junior or Senior Prom
 - Receive a report card
 - Receive official transcripts/records
 - Receive a diploma
 - Attend Graduation
6. As a condition of The Ursuline School accepting the above-named student, Parents/Students agree to follow the policies and procedures set forth in the current Parent/Student Handbook which is incorporated herein by reference. The policies and procedures set forth in the Parent/Student Handbook may be modified or amended at any time and without notice.
7. In addition to the reasons set forth in the Parent/Student Handbook, The Ursuline School has the right to suspend or terminate the enrollment of a student at any time. Such a suspension or termination may result where: (i) a parent/guardian or student fails to abide by the rules, regulations or policies of the School; (ii) the School determines, in its sole discretion, that a parent/guardian/student's conduct or performance demonstrates an unwillingness or inability to be productive within the School community; or (iii) the School determines, in its sole discretion, that the continued attendance of a student in the School is not in the best interest of the student or the School.
8. Students at The Ursuline School are periodically photographed or videotaped while taking part in a school activity for our website or our Development and Recruitment campaigns, and for other educational or promotional uses. If you wish for your child not to be included, please check the line below. This permission will be in effect for one year from the date signed on this Contract.

_____ I do NOT give permission for my child's image to be used by the school in print and non-print publications for educational and promotional purposes while at Ursuline School.

Father or Guardian name (please print)

Mother or Guardian Name (please print)

Father or Guardian email (please print)

Contact Phone

Mother or Guardian email (please print)

Contact Phone

Father or Guardian signature

Date

Mother or Guardian signature

Date



THE URSULINE SCHOOL

Dear Incoming Koalas and Parents,

The Health Office would like to welcome you to The Ursuline School (TUS). In order to make your transition to TUS go smoothly, the following documents are required:

- The most recent immunization record
- The most recent physical from the doctor.
- The School Health History completed by a parent.
- An Allergy Action Plan (if applicable)
- An Asthma Action Plan (if applicable)
- Medication Administration Form completed by a parent/guardian and physician for any student who requires daily medication to be given at school and/or Over the Counter medication to be given as needed. ***No medication can be given in school to any student without a doctor's order and parent signature.***
- Health forms can be submitted to health@ursulinenewrochelle.org or submitted during registration.

The health services department helps to oversee compliance with immunizations according to NYS law. The following immunizations are required for school entrance.

Immunization	Number of Doses
Diphtheria/Tetanus/Pertussis (DTaP/DTP)	3-4 doses (the last dose must be given after the age of 4)
Tetanus/Diphtheria/Pertussis (Tdap)	1 dose (required by age 11)
Polio	4 doses or 3 doses if the 3rd dose given at 4 years of age or older
Measles/Mumps/Rubella (MMR)	2 doses (first dose given after first birthday)
Hepatitis B	3 doses or 2 doses of adult Hepatitis B Vaccine (Recombivax) for children who received doses at least 4 months apart between ages 11 through 15 years
Varicella (Chickenpox)	2 doses
Meningococcal conjugate (MenACWY)	1 dose: Grades 7, 8, 9, 10, & 11* 2 doses (or 1 dose if given on or after age 16): Grade 12 *MenACWY is a required vaccine for 7th grade entrance.

The Covid-19 vaccine is strongly encouraged but is not mandatory for students in NY State *at this time*.

Thank you and feel free to contact me with any questions.

Kind regards,

Mrs. [Janice Holderman](mailto:holdermj@ursulinenewrochelle.org), RN, MA
holdermj@ursulinenewrochelle.org

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: <i>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.</i>									
BMI _____ kg/m2 Percentile (Weight Status Category): ☐ <5 th ☐ 5 th -49 th ☐ 50 th -84 th ☐ 85 th -94 th ☐ 95 th -98 th ☐ 99 th and >									
Hyperlipidemia: ☐ 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: _____			
						☐ Mental Health: _____			
						☐ Other: _____			
Lead Level Required Grades Pre- K & K				Date					
☐ Test Done		☐ Lead Elevated ≥ 10 $\mu\text{g/dL}$							
☐ System Review and Exam Entirely Normal									
Check Any Assessment Boxes <u>Outside</u> 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:			<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 70%;">Diagnoses/Problems (list)</th> <th style="width: 30%;">ICD-10 Code</th> </tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black; height: 20px;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black; height: 20px;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black; height: 20px;"></td></tr> </table>		Diagnoses/Problems (list)	ICD-10 Code						
Diagnoses/Problems (list)	ICD-10 Code											
☐ Additional Information Attached												

Rev. 5/4/2018 Page 1 of
2

Name:				DOB:	
SCREENINGS					
Vision	Right	Left	Referral	Notes	
Distance Acuity	20/	20/	☐ Yes ☐ No		
Distance Acuity With Lenses	20/	20/			
Vision – Near Vision	20/	20/			
Vision – Color ☐ Pass ☐ Fail					
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 NYSIIS

Received 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.



CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender:
Parent/Guardian Name:	Grade:	Home Phone:	Cell:
	Email:		Date:

Your Child's Medical History	YES	NO	If Yes, please explain and include date:
Born premature or had complications after birth	☐	☐	
Has an ongoing medical or developmental condition	☐	☐	
Sees a medical specialist	☐	☐	
Has severe allergies or anaphylaxis	☐	☐	☐ Food ☐ Environmental ☐ Insect ☐ Medication ☐ Other Specify:
Has been hospitalized	☐	☐	
Had an operation/required surgery	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion, has a seizure disorder , or epilepsy	☐	☐	
Has a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Has a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Wears a dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|--|---|---|
| ☐ ADHD | ☐ GI Conditions (ulcer, reflux, IBS) | ☐ Scoliosis/Orthopedic Impairment |
| ☐ Allergies | ☐ Headaches/migraines | ☐ Single Organ (☐ kidney, ☐ testicle) |
| ☐ Asthma | ☐ Heart Condition | ☐ Skin Condition |
| ☐ Autism | ☐ High Blood Pressure | ☐ Speech Condition |
| ☐ Diabetes | ☐ Mental Health Condition | ☐ Urinary Condition |
| ☐ Ear Infections | (Depression, eating disorder, anxiety, OCD, ODD, etc.) | ☐ EI/CPSE/CSE services _____ |

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ wheelchair ☐ other:
TREATMENTS	YES	NO	
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ inhaler/nebulizer/peak flow monitoring ☐ special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

Please list any additional concerns:

Parent/Guardian Signature: _____ Date: _____

**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

City School District of New Rochelle

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No**PLACE
PICTURE
HERE****NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.****Extremely reactive to the following allergens:** _____**THEREFORE:**☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.**FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS****LUNG**

Shortness of breath, wheezing, repetitive cough

**HEART**

Pale or bluish skin, faintness, weak pulse, dizziness

**THROAT**

Tight or hoarse throat, trouble breathing or swallowing

**MOUTH**

Significant swelling of the tongue or lips

**SKIN**

Many hives over body, widespread redness

**GUT**

Repetitive vomiting, severe diarrhea

**OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.**1. INJECT EPINEPHRINE IMMEDIATELY.****2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS**NOSE**

Itchy or runny nose, sneezing

**MOUTH**

Itchy mouth

**SKIN**

A few hives, mild itch

**GUT**

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE.****FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



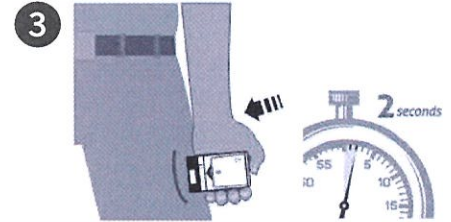
FARE

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

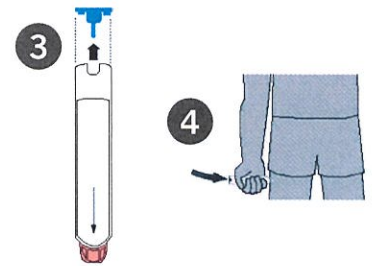
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



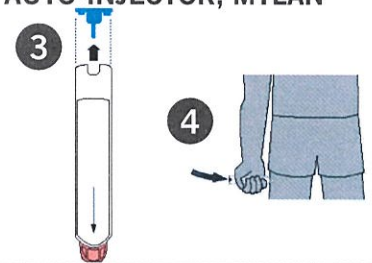
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



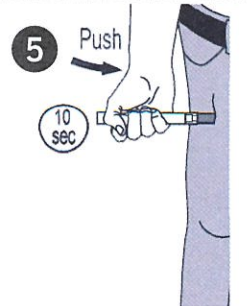
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____
 DOCTOR: _____ PHONE: _____
 PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____
 PHONE: _____
 NAME/RELATIONSHIP: _____
 PHONE: _____

Asthma Action Plan

Date Completed _____

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [☐ Mild ☐ Moderate ☐ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

GREEN ZONE: GO!

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

- ☐ No daily controller medicines required
- ☐ Daily controller medicine(s): _____
- ☐ _____
 Take _____ puff(s) or _____ tablet(s) _____ daily.
- ☐ For asthma with exercise, ADD: _____,
 _____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

- ☐ _____ inhaler _____ mcg
 Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask.
- ☐ _____ nebulizer _____ mg / _____ ml
 Take a _____ nebulizer treatment every _____ hours, if needed.
- ☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

- ☐ _____ inhaler _____ mcg
 Take _____ puffs every _____ hours, if needed. Always use a spacer, some children may need a mask.
- ☐ _____ nebulizer _____ mg / _____ ml
 Take a _____ nebulizer treatment every _____ hours, if needed.
- ☐ Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ – _____.

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

DEI8DC.A E1GB8HH8DCH4DG8C01E1C01CIB108/I8DC/GGO.COLH1.IH/7DDA

7WR_gj/ReWEeciJVWe8bVWdWbVWbg/ReekRbVlWEWeaJff]dattest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____



Department of
Education

Christopher McKay, Director
Bureau of Non-Public School Payables

**STATEMENT OF PARENT IN SUPPORT OF HEALTH SERVICE CLAIM
FOR A NEW YORK CITY RESIDENT CHILD**

SCHOOL YEAR ENDING JUNE 30.	NOTE TO CLAIMING SCHOOL DISTRICT - PLEASE COMPLETE ALL INFORMATION. IT WILL HELP TO ENABLE US TO PROCESS YOUR CLAIM MORE EFFICIENTLY. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TUITION UNIT AT (718)935-2938		DATE
CLAIMING SCHOOL DISTRICT INFORMATION	OFFICIAL DESIGNATION OR TITLE OF SCHOOL DISTRICT		
SCHOOL DISTRICT FEDERAL TAX ID NUMBER			
MAILING ADDRESS: NUMBER & STREET, CT	City School District of New Rochelle 515 North Avenue New Rochelle, New York 10801 Tax ID #13-6007142		
FORM PREPARED BY (OR CONTACT PERSON) PRINT NAME	NUMBER (INCLUDE AREA CODE)		
Health Services Department	914 576 4300		
STUDENT INFORMATION	PRINT OR TYPE ALL INFORMATION EXCEPT SIGNATURES		GRADE
DATE OF BIRTH (MM/DD/YY)	STUDENT'S LAST NAME	FIRST NAME INITIAL	
NAME AND ADDRESS OF NON-PUBLIC SCHOOL CHILD IS ATTENDING			
The Ursuline School 1354 North Avenue New Rochelle, New York 10804			
PARENT/GUARDIAN STATEMENT	PRINT NAME OF PARENT/GUARDIAN BELOW		
I, _____, Parent/Guardian			
of the student named above hereby affirm:			
1. That I am a legal resident of New York City residing at:			
PRINT HOME ADDRESS (NUMBER AND STREET, BOROUGHS, ZIP CODE - PO BOXES ARE NOT ACCEPTABLE)			
and intend to reside at this address throughout the school year referred to above. In the event of a change of residence to a location outside of New York City, notice of such change will be furnished, in writing, to the Department of Education of the City of New York, Non-Resident Tuition Unit, 85 Court Street - Room 1503, Brooklyn, NY 11201.			
2. That my child, named above, is on the register of the aforementioned school for the school year referred to above and was on the school's register as of October 1st of that year.			
AFFIRMED:			
SIGNATURE OF PARENT/GUARDIAN		NEW YORK CITY TELEPHONE NUMBER (INCLUDE AREA CODE)	
Subscribed to me on _____		SIGNATURE AND TITLE OF NON-PUBLIC SCHOOL OFFICIAL	
DATE			
FOR NYC DOE USE ONLY		VERIFIED BY:	



THE URSULINE SCHOOL

2023-2024

NEW YORK STATE TEXTBOOK LOAN REQUEST

Student's Name: _____

Current Address: _____

Street

City

State

Zip

Each year New York State provides some funding to each school district for the purchase of textbooks. These New York State Textbook Loan (NYSTL) funds are allocated based on the number of students in the district. It is extremely important that we have an accurate record of students in each school district.

Please list the SCHOOL DISTRICT, CITY and STATE to which you pay school taxes each year.

SCHOOL DISTRICT

CITY

STATE

REQUIRED:

Student Signature: _____ Date: _____

Student's grade for 2023-2024 school year: _____

Parent/Guardian agrees and understands that all textbooks loaned to the non-public school student remain the property of the School District and have to be returned at the end of the non-public student's school year. The Parent/Guardian understands and agrees that should the book(s) not be returned or returned damaged, normal wear and tear accepted, the Parent/Guardian is responsible for the replacement costs of each book.

Parent Signature: _____ Date: _____

Please complete and return this form no later than **March 1, 2023** to:

The Ursuline School, 1354 North Ave, New Rochelle, NY 10804 or email julesj@ursulinenewrochelle.org



THE URSULINE SCHOOL

MATHEMATICS

2023-2024 COURSE INFORMATION SURVEY

To be completed by student's **current Math teacher** for proper math placement **ONLY** if student is **currently taking Algebra level 1 or higher**.

Please return to: *Admissions Office, The Ursuline School, 1354 North Avenue, New Rochelle, NY 10804* or email to hersprim@ursulinenewrochelle.org by March 1, 2023.

STUDENT'S NAME: _____

PRESENT SCHOOL: _____

Please indicate the Math course student is presently taking: _____

Will the student take the Algebra 1 Regents in June? Y / N

Semester 1 Grade in January 2023 _____ Mid-term Exam Grade in 2023 _____

Math ability (please check): Excellent _____ Good _____ Fair* _____ Weak* _____

Current Math Teacher recommended placement for this student, refer to our website for course description: www.ursulinenewrochelle.org

Geometry 9H (1.6 weight) _____ Accelerated Geometry 9 (1.5 weight) _____ Algebra I (1.4 weight) _____

****Please note:** All incoming 9th graders are required to purchase a **TI-Nspire CX II Calculator** for Mathematics.

Additional Comments:

*If ability is noted as fair or weak, would you recommend summer remediation? Please comment on areas of weakness.

Teacher (please print name) Teacher's signature Teacher's email address Date

PLEASE NOTE: All students who hope to be placed into a higher level mathematics course will be required to take a math placement test after school during the week of March 13 - March 16, 2023. Additional details will be sent to the primary email address provided to Admissions.



THE URSULINE SCHOOL

WORLD LANGUAGES

2023-24 COURSE INFORMATION SELECTION

STUDENT'S NAME: _____

PRESENT SCHOOL: _____

Which world language do you wish to study next year? (Check one.)

ITALIAN _____ LATIN _____ SPANISH _____ MANDARIN _____

Is there another language spoken at home? Y___N___ If yes, please indicate language _____

Is your child fluent in that language? Y___N___

Do you intend to take the Ursuline Language Placement Test? Y___N___ If Yes, please have current Language teacher complete Language Survey below. **Please note: if you do not attend the placement test, you will be placed in Level 1 of the selected language.**

Parent/Guardian signature: _____ Date: _____

LANGUAGE SURVEY

PLEASE NOTE: The information requested below needs to be completed by student's current teacher in order to be considered for Language Placement. Please have student's teacher return the completed form by email, fax or hard copy to: *Admissions Office, The Ursuline School, 1354 North Avenue, New Rochelle, NY 10804* or hersprim@ursulinenewrochelle.org no later than **March 1, 2023**.

Indicate the language the student is learning at present: _____

Text used: _____

First semester language grade in January 2022: _____

Language ability (please check): Excellent _____ Good _____ Fair _____ Weak _____

Will the student have completed an equivalent of the first year of a high school language course? Y___N___

How many times a week does class meet? _____

PLEASE NOTE: All students who are studying Spanish, Italian or Latin and wish to continue studying the language in 9th grade will be required to take a language placement test at The Ursuline School after school during the week of **March 13-16, 2023**. Additional details will be sent to the primary email address provided to Admissions.

Teacher (please print name)

Teacher's signature

Teacher's email address

Date

1354 North Avenue | New Rochelle, NY 10804 | 914.500.6212 | fax 914.636.3949

johnstone@ursulinenewrochelle.org

Educate | Inspire | Empower



THE URSULINE SCHOOL

SCIENCE

2023-2024 COURSE INFORMATION SURVEY

Form to be completed **ONLY IF** student would like to be considered for honors or advanced science course placement.

To be completed by the student's **current Science teacher**. Please return to:

Admissions Office, The Ursuline School, 1354 North Avenue, New Rochelle, NY 10804 or email hersprim@ursulinenewrochelle.org by March 1, 2023.

STUDENT'S NAME: _____

PRESENT SCHOOL: _____

Please verify the Science course the student is presently taking by checking the box that applies.

<p>_____ Living Environment</p> <p>Will she take the Living Environment Regents in June 2023?</p> <p>_____ Yes _____ No</p> <p>NOTE: Students who would like to be considered for placement into Earth Science Honors or Chemistry will be required to take a Science placement test (see details below).</p>	<p>_____ Other Science Course</p> <p>Please specify:</p> <p>_____</p> <p>NOTE: Students who would like to be considered for placement into Biology Honors will be required to take a Science placement test (see details below).</p>
---	---

Semester 1 grade in January 2023 _____ Midterm Exam Grade in 2023 (if applicable) _____

Science ability (circle one): Excellent Good Fair Weak

Ability to handle advanced or honors-level course work: Excellent Good Fair Weak

Additional Comments:

Teacher's Name (please print)

Teacher's Signature

Date

PLEASE NOTE: Placement tests will be offered after school during the week of March 13-16, 2023. Additional details will be sent to the primary email address provided to Admissions.

1354 North Avenue | New Rochelle, NY 10804 | 914.636.3950

Educate | Inspire | Empower