2015-2016 ELEMENTARY SCHOOL NEW STUDENT REGISTRATION FORM

Light of Christ Catholic Schools

Circle Grade entering 2015-2016 school year:

Grade: K 1 2 3 4 5 6

School (*preference*): ______________________________

Pre-K 3: MWF - AM
Pre-K 4: M through F - AM only
Pre-K 4: M through F - Full day

Note: Your child will also need a birth certificate, baptismal certificate and current immunization records prior to the first day of school.

Student Name: ____ Nickname: ____________________ D.O.B. _____/_____/_____
LAST FIRST MIDDLE

Address: ____ City: _________________ State: _______ Zip: ____________

Ethnicity (circle one): American Indian Caucasian African American Hispanic Asian Pacific Islander

Sex: M F

No. of Brothers: _____ Sisters: _____

Father Information

Name: ____

If different:
Address: ____
____

Phone: __________________ Cell Phone: _________________

Employer: ____

Work Phone: ____

Religion: ____________________ Parish: __________________

Email: ____

Marital Status: _____________________________

☐ if **not** married – this parent should receive mailings from the school

Mother Information

Name: ____

If different:
Address: ____
____

Phone: __________________ Cell Phone: _________________

Employer: ____

Work Phone: ____

Religion: ____________________ Parish: __________________

Email: ____

Marital Status: _____________________________

☐ if **not** married – this parent should receive mailings from the school

Name & Address of school last attended: __________________________________ Public School which you would attend: ______________________

Light of Christ Catholic Schools ☙ 1025 N 2nd St ☙ Bismarck, ND 58501 ☙ (701) 751-4883

☙ CONTINUE ON BACK ❧

LIVING ARRANGEMENTS

Student Currently Lives with (circle one): Both Parents Father Only Mother Only Other (please describe): ______________________

If there is a Step-Parent or other Guardian, please provide that information:

Name #1: ______________________________

Relationship: ______________________________

If different:
Address: ______________________________

____

Phone: ______________ Cell Phone: ________________

Employer: ______________________________

Work Phone: ______________________________

Name #2: ______________________________

Relationship: ______________________________

If different:
Address: ______________________________

____

Phone: ______________ Cell Phone: ________________

Employer: ______________________________

Work Phone: ______________________________

EMERGENCY INFORMATION

IN CASE OF LOCAL EMERGENCY (OTHER THAN PARENT)

1) Contact Name: ________________________ Number to call: ________________________ Relationship to Student: ________________

2) Contact Name: ________________________ Number to call: ________________________ Relationship to Student: ________________

MEDICAL INFORMATION

Doctor: ______________________________ Doctor Phone: _________________________ Preferred Hospital: ______________________________

LIFE THREATENING ALLERGIES: ____ OTHER ALLERGIES: _______________________________

Will this student have an Epi-Pen at school? YES NO Will this student have a rescue inhaler at school? YES No

Medications (list type and reason): ____

Health Conditions (circle all that apply): DIABETES SEIZURES ASTHMA other:____

Has your child ever been ill with CHICKENPOX? YES NO If "yes", when: ____

Other Medical Information of Concern: ____

Has your child ever received Special Education, Title I or 504 Services? YES NO

If "yes", indicate dates, school district, and which services: ____

Are there any behavior or learning concerns we should be aware of: ____

Signature of Parent: ____ **Date:** ____________________________