



Student Enrollment Form

Complete one form per child (front & back)

SCHOOL YEAR: 2010-1011

GRADE:

<u>Child's Name</u> Last: _____ First: _____ Middle: _____ Nickname: _____	<u>Sex</u> Male <input type="checkbox"/> Female <input type="checkbox"/>	Parent Name _____ Street: _____ City: _____ State: _____ Zip _____ Phone Number: (____) _____ - _____
	<u>US Citizen</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	

<u>Birth Date</u> ____ / ____ / ____ <u>Birth Place:</u> City _____ County _____ State _____ Country (if outside USA) _____	<u>Resides with (check one)</u> Both <input type="checkbox"/> *Mother <input type="checkbox"/> *Father <input type="checkbox"/> *Other <input type="checkbox"/> : _____ <i>*If checked a Court Ordered Final Judgment (custody papers) must be submitted to the Main Office.</i> Does other parent have shared custody? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Ethnic Origin of Child
(This is used for State/Diocesan statistical purposes.)

Caucasian Hispanic
 African-American Asian/Pacific Islander
 Native American Multi-Racial

Language spoken at home: _____

Academic Information

Transferring From (if applicable):

School Name _____

Street Address _____

City _____ State _____ Zip _____

***Kindergarten Use Only:** Did the student attend VPK? Yes No

Has the student ever repeated a grade? Yes No

If so, which Grade(s)? _____

Has the student ever been suspended/expelled from any school? Yes No

Psychological

Please submit psychological test results

N/A ADD ADHD
 SLD Please list disability _____

Is your child taking any medication associated with this disability?
 Yes No
 If yes, please specify:

Sacraments

Catholic (please check all sacraments your child has received)

Baptized Penance
 Holy Eucharist Confirmation

Non-Catholic

Baptized
 Religion _____
 Church _____

Medical Information

Is student currently taking *medication on a regular basis? If yes please specify in the box below.

Prescription (medication prescribed by a physician)

Diagnosis (i.e. Asthma)	Medication	Dosage	Frequency

Non-Prescription (over-the-counter medication)

Condition	Medication	Dosage	Frequency

*Please refer to school handbook for medication policy. Medication forms are available in the office.

Does your child have any allergies? _____ If yes, please specify: _____

Does your child have asthma? _____ Current treatment: _____

The following information must be enclosed with the application:

- ❖ Birth Certificate
- ❖ Baptismal Certificate (Catholic)
- ❖ Social Security Card
- ❖ Recent report card and previous two years report cards (if applicable)
- ❖ Standardized Tests (grades 2-8)
- ❖ Psychological Test Results (if applicable)

I, _____

(Print First & Last Name)

acknowledge that I have completed the application, student enrollment and medical information forms to the best of my knowledge. If any information changes I will notify the school office in writing as soon as it occurs.

Signature **Date**

Florida Department of Health

****OFFICIAL USE ONLY****

Student Health Examinations (Gold/Yellow Form)

Date: _____

Certificate of Immunization (Blue Form)

Completed: _____ Date to be completed by: _____

For Office Use Only:

Date Received: _____

Accepted: _____ Registration sent: _____