

# Angelo Catholic School Registration

San Angelo, Texas

For Office Use Only

Date Enrolled \_\_\_\_\_  
Reg Fee Paid \_\_\_\_\_  
Imm. Record \_\_\_\_\_  
Birth Cert \_\_\_\_\_  
Bapt. Cert \_\_\_\_\_  
Sacraments \_\_\_\_\_  
Withdrawal Date \_\_\_\_\_  
Reason \_\_\_\_\_

Enrollment Card 20\_\_ - 20\_\_

Student Name \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Age on Sept 1 \_\_\_\_\_  
(Legal Last Name) (First Name) (Middle Name)

Goes By \_\_\_\_\_ Birthdate \_\_\_\_\_ Place of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. # \_\_\_\_\_ Zip \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Grade Entering: \_\_\_\_\_ Student's Social Security # \_\_\_\_\_

Religion \_\_\_\_\_ Parish Registration \_\_\_\_\_

Last school attended other than Angelo Catholic School \_\_\_\_\_

Neighborhood School \_\_\_\_\_ With whom does student live? \_\_\_\_\_

Father/Step Father/Guardian (Please circle one) \_\_\_\_\_ Phone \_\_\_\_\_

Father/Step Father/Guardian's Home Address: \_\_\_\_\_ Cell \_\_\_\_\_

Father/Step Father/Guardian's Place of Work \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother/Step Mother/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Mother/Step Mother/Guardian's Home Address: \_\_\_\_\_ Cell \_\_\_\_\_

Mother/Step Mother/Guardian's Place of Work: \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_ Language spoken at home \_\_\_\_\_

Person Responsible for tuition payments \_\_\_\_\_ Phone \_\_\_\_\_

Please list other children in household under 18 years of age:

| Legal Last Name | Legal First Name | Age   | Sex   | School Attending |
|-----------------|------------------|-------|-------|------------------|
| _____           | _____            | _____ | _____ | _____            |
| _____           | _____            | _____ | _____ | _____            |
| _____           | _____            | _____ | _____ | _____            |

Is parent/step-parent in armed services: Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever been involved in any special school program, i.e. Special Education, Accelerated Program, Hearing Program, Handicapped, Remedial Instruction, etc.? \_\_\_\_\_ Yes \_\_\_\_\_ No

The individuals below have permission to pick up my child from school or may be called in case of an emergency:

(Mother's Name) \_\_\_\_\_ Primary Number \_\_\_\_\_

(Father's Name) \_\_\_\_\_ Primary Number \_\_\_\_\_

(Other) \_\_\_\_\_ Relationship \_\_\_\_\_ Primary Number \_\_\_\_\_

(Other) \_\_\_\_\_ Relationship \_\_\_\_\_ Primary Number \_\_\_\_\_

In order to better serve your child's health needs, please check if any items listed below apply, and explain, if necessary.

- ( ) Allergy            If so, to what? \_\_\_\_\_  
                              Requires Medication? ( ) yes ( ) no  
                              Name of medication \_\_\_\_\_
- ( ) Food Allergy    If so, to what? \_\_\_\_\_  
                              Special requirements? \_\_\_\_\_
- ( ) Asthma            If so, requires medication / inhaler? ( ) yes ( ) no  
                              Name of medication \_\_\_\_\_  
                              How often? \_\_\_\_\_ Taken at school? \_\_\_\_\_
- ( ) ADHD             If so, requires medication? ( ) yes ( ) no  
                              Name of medication \_\_\_\_\_
- ( ) Diabetes         If so, what type? \_\_\_\_\_ Medication? ( ) yes ( ) no  
                              Name of medication \_\_\_\_\_
- ( ) Ear                Frequent infections? ( ) yes ( ) no  
                              Hearing loss? ( ) yes ( ) no
- ( ) Seizure          Requires Medication? ( ) yes ( ) no  
                              Name of medication \_\_\_\_\_
- ( ) Heart             If so, requires medications? ( ) yes ( ) no  
                              Name of medication \_\_\_\_\_
- ( ) Orthopedic      Explain \_\_\_\_\_
- ( ) Vision            Wears glasses? ( ) yes ( ) no  
                              Contacts? ( ) yes ( ) no
- ( ) Others Explain \_\_\_\_\_

Please list any other medications your child takes on a regular basis.

\_\_\_\_\_  
\_\_\_\_\_

Please list any other important health information \_\_\_\_\_

My child may participate in health checks conducted at school. ( ) Yes ( ) No

**Any student taking prescription medication from school personnel needs a "Medication Request" form completed annually per medication before the medication can be given.**

**No over the counter medicines (Tylenol, Motrin, etc.) are allowed to be given by the school unless accompanied by a doctor's prescription/note.**

In the event I may not be reached, I authorize the principal or other professional employee to consent to emergency medical treatment for my child's minor illness or injury. I also authorize emergency transportation of my child by available emergency medical services.

Local Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Hospital Preference \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**Optional**

How did you hear about our school? Please check as many as apply.

Church Bulletin \_\_\_\_\_

Newspaper \_\_\_\_\_

Radio \_\_\_\_\_

TV \_\_\_\_\_

Friend recommended \_\_\_\_\_ (If possible, please give name \_\_\_\_\_)

Other \_\_\_\_\_ (Please specify) \_\_\_\_\_