ST. CATHERINE LABOURE SCHOOL

Unpaid or incomplete applications will not be accepted. A non-refundable testing fee is required with this application. **Please print.**

Date of application _____ Grade child is applying for: _____

Child's Last Name ↑ First Middle Sex Birth Date Birthplace

Father's Last Name First Middle Birthplace Religion Occupation Marital Status

Mother's Last Name First Maiden Name Birthplace Religion Occupation Marital Status

Guardian - Last Name First Middle Birthplace Religion Occupation Marital Status
(if other than parent)

Child's Address ↑ City State Zip Code (____) Phone Number

School or Kindergarten NOW Attending Address of School City Zip Code

Date of Baptism Name of Church City State

Date of 1st Communion Name of Church City State

Date of Confirmation Name of Church City State

For Office Use Only IP OP NC NR

Rate _____

STUDENT HEALTH INFORMATION

(please print)
LAST NAME_____ FIRST NAME_____ MIDDLE NAME_____ DOB_____

FATHER'S LAST NAME_____ FIRST NAME_____ MIDDLE NAME_____

OCCUPATION_____BUSINESS ADDRESS_____BUSINESS PHONE_____

MOTHER'S LAST NAME_____ FIRST NAME_____ MIDDLE NAME_____

OCCUPATION_____BUSINESS ADDRESS_____BUSINESS PHONE_____

EMAIL ADDRESS (please print clearly) Mother_____ Father_____

LANGUAGE SPOKEN IN HOME_____ SECOND LANGUAGE SPOKEN IN HOME _____

IMMUNIZATION AND TEST INFORMATION Please use complete dates (month/ day/ year)

Polio (Salk or Sabin (Oral) 1st _____ 2ND_____ 3rd _____ 4th (if required)_____

DPT or D.T. (Diptheria, pertussis, tetanus) 1st _____ 2nd _____ 3rd _____ 4th _____ 5th (if required)_____

Hepatitis B 1st _____ 2nd _____ 3rd _____

(**M.M.R**.) Measles: Rubeola (10 DAY); Mumps; & Rubella (German - 3 Day); 1st _____ 2nd (Kindergarten or 7th gr)_____

Mantoux T.B. Test (**PPD**) _____ _____ _____ Chest X-Ray _____ _____
Date Taken Date Read Results Date Results

Varicella (Chicken Pox) _____

Approximate dates of illnesses: Measles_____Chicken Pox_____ Other _____ Operations_____

Wears Glasses?_____ Has Asthma?_____ If Yes, medication _____

Name of Physician or agency child sees: _____Phone Number_(_____)_____

List any health condition which the school should be aware of. _____

List any medications your child takes regularly. _____

ST. CATHERINE LABOURE SCHOOL

The following information is necessary for us to have for school forms and for emergency purposes. Please fill out completely. **(PLEASE PRINT**).

_____(_____)_____

Student's Full Name Address City Zip Home Phone Number

ETHNIC ORIGIN (Check One)

___ American Indian
___ Asian
___ Black
___ Caucasian – Hispanic
___ Caucasian – non Hispanic
___ Filipino
___ Multiracial

_____

PARENT INFORMATION:

Catholic Yes_____ No _____

Are you registered member of St. Catherine Laboure Parish?
(You have filled out a registration form at church rectory and are using envelopes) Yes_____ No_____ Envelope #_____

Members of another neighboring parish Yes_____ No_____ If yes, please indicate name of Parish_____

Reasons for enrolling your student in this school. _____

How did you **FIRST** find out about our school? _____

What or who brought you to our school? _____

Do you have any other children/relatives currently enrolled in St. Catherine's? If yes, please name and give relationship _____

_____

EMERGENCY INFORMATION;

Can father be reached at work in an emergency? Yes_____ No_____ Phone No (including area code) ._____

Can mother be reached at work in an emergency? Yes_____ No_____ Phone No (including area code) ._____

Neighbor or relative who can be reached in an emergency. _____ Phone No (including area code) _____