

Registration 2011-2012

St. Patrick's School
3583 30th Street
San Diego, CA 92104
(619) 297-1314
Fax (619) 297-3346

Office Use Only

Registration 2010-11

Immunization Records Received:	<input type="checkbox"/>
Baptismal Record Received:	<input type="checkbox"/>
Contract Signed & Received:	<input type="checkbox"/>
Tuition Category:	

Directions: Please complete the following information and return it to the school office. (Please Print)

Today's Date _____ Grade for which you are applying _____ Referred by: _____

I. Student Information

Family Name: _____ Child's Name: _____ Male Female Ethnic Origin: Caucasian
 African American
 Hispanic
 Asian
 Native American
 Pacific Islander

Student's Current Address: _____
Home Phone _____ Street _____ City _____ State _____ Zip _____
Date of Birth: _____ Place of Birth: _____ Religion: _____ U.S. Citizen: Yes No
Nearest public school _____ Entering this school from: Name of school: _____
Street: _____
City, State, and Zip _____

If Catholic, parish in which you live: _____ Parish in which you are registered: _____

Sacrament	Sacrament Received	Location	Church	Date
Baptism	<input type="checkbox"/> Y <input type="checkbox"/> N			
Penance	<input type="checkbox"/> Y <input type="checkbox"/> N			
First Communion	<input type="checkbox"/> Y <input type="checkbox"/> N			

II. Parent Information:

Y N

Father's Last Name _____ First Name _____ Initial _____ U.S. Citizen _____ Religion _____ Occupation _____ Business Address _____ Business Phone _____
cell _____

Y N

Mother's Last Name _____ Maiden Name _____ First Name _____ Initial _____ U.S. Citizen _____ Religion _____ Occupation _____ Business Address _____ Business Phone _____

Please Check What Applies:

<input type="checkbox"/> Father Deceased	<input type="checkbox"/> Mother Deceased	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Single Parent Family
<input type="checkbox"/> Mixed Religion	<input type="checkbox"/> Parents Divorced	<input type="checkbox"/> Father Separated	<input type="checkbox"/> Two Parent Family
<input type="checkbox"/> Mother Separated	<input type="checkbox"/> Father Re-married	<input type="checkbox"/> Mother re-married	

Custody of Child: Mother Father Both Other(specify) _____

Is there a Court Order regarding custody or visitation rights? Yes No Does the School have a Copy? Yes No

Child lives with: Mother Father Both Other (complete the following regarding the person with whom the child lives):

Last Name	First Name	Initial	Relationship (to child)	Religion	Occupation	Business Address	Business Phone

Signature of person completing this form

Print Full Name

Relationship to child

Health History

(To be completed by parent or guardian)

Directions: Please complete the following information and return it to the school office. (Please Print)

Current Date _____

I. General Information:

Student's Name: _____ Date of Birth: _____ Place of Birth: _____ Male Female
Last First Initial Month Day Year City State

Address: _____ Telephone Number: _____
Street City State Zip

Father Name: _____ Mother Name: _____ School: _____
Last First Initial Last Maiden First Initial

II. Significant Health History (If you check an item, please indicate the year the incident, difficulty, disease was first diagnosed. If requested please give a brief explanation of the disease, difficulty or incident.)

Yes	No	Year	Yes	No	Year	Yes	No	Year	Yes	No	Year
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Colds _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Ear Infections _____ Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defect _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint, muscle problems _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder _____ Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems _____ Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever _____	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever _____	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox _____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps _____	<input type="checkbox"/>	<input type="checkbox"/>	Measles _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Mono _____

III. Allergies (Please check what applies to your child. Give a brief explanation where requested)

Yes <input type="checkbox"/> No <input type="checkbox"/> Medications Explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Bee sting requiring treatment	Yes <input type="checkbox"/> No <input type="checkbox"/> Food Explain: _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Other: List and Explain _____ _____
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IV. Known Eye and Hearing Problems (Please check what applies to your child)

Yes <input type="checkbox"/> No <input type="checkbox"/> Glasses	Yes <input type="checkbox"/> No <input type="checkbox"/> Contact Lenses	Yes <input type="checkbox"/> No <input type="checkbox"/> Preferential Seating	Under Care of Dr. _____
Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing Aid	Yes <input type="checkbox"/> No <input type="checkbox"/> Preferential Seating	Under Care of Dr. _____	

V. Other Information

Date of Last Physical Examination _____ Date of Last Dental Examination: _____
Month Year Month Year

Yes No Is there any other information regarding the health of your child that you feel would be important for the school to know? Explain below:

Yes No Is the child taking any medication? List and give dosage:

