



DIOCESE OF SPRINGFIELD

Student Re-registration

For school year beginning

_____/_____/_____
Month Year

Student Information

Enrollment for Grade: ____

Male Female
Gender

_____/_____/_____
Last Name First Name Middle Name

_____/_____/_____
Address (PO Box, if applicable) City State Zip Telephone Number

_____/_____/_____
Date of Birth Place of Birth Religion Parish City

Yes No Will the above named child require busing?

Responses to the following item are not required. However, your assistance with this information is greatly appreciated.

Race: American Indian Black (not of Hispanic origin) Asian Hispanic White (not of Hispanic origin)

Family Information

Father:

_____/_____/_____
Last Name First Name () Home Telephone

_____/_____/_____
Occupation Place of Employment City State () Work Telephone

Mother:

_____/_____/_____
Last Name First Name Maiden Name () Home Telephone

_____/_____/_____
Occupation Place of Employment City State () Work Telephone

List Sibling Information:

Name	Age	Gender	School	Name	Age	Gender	School
_____/_____/_____/_____/_____	_____	_____	_____	_____/_____/_____/_____/_____	_____	_____	_____
_____/_____/_____/_____/_____	_____	_____	_____	_____/_____/_____/_____/_____	_____	_____	_____

Student Lives With:

Mother and Father Mother Father Mother and Stepfather Father and Stepmother Other _____

Name of Student's Legal Guardian (if applicable):

_____/_____/_____
Last Name First Name

Name of Student's Stepparent (if applicable):

_____/_____/_____
Last Name First Name

Student Medical and Emergency Information

Emergency Contacts (other than child's parents or guardians):

_____	_____	_____	() _____
Full Name	Full Address	Relationship	Telephone
_____	_____	_____	() _____
Full Name	Full Address	Relationship	Telephone
_____	_____	_____	() _____
Full Name	Full Address	Relationship	Telephone

Medical:

_____	_____	_____	_____	() _____
Physician's Name	Address	City	State	Telephone
_____	_____	_____	_____	() _____
Dentist's Name	Address	City	State	Telephone

_____	_____	_____
Name of Policy Holder (Medical Insurance)	Company Name	Group Number

If you do not have medical insurance, the diocese requires that you purchase school accident insurance.

Yes No _____
Does your child have any food allergies (for example, peanuts)? If yes, please list.

Yes No _____
Does your child have allergic reactions (for example, bee stings)? If yes, please list.

Yes No _____
Does your child take medications on a daily basis? If yes, please list.

Yes No Does your child require medication be administered during school hours?

Yes No Does your child require special education services?

Is there anything else you would like us to know about your child?

Agreements

Individual Responsible for Payment of Tuition and Fees:

_____	_____	_____	_____	_____	() _____
Last Name	First Name	Address	City	State	Telephone

In registering our child, I (we) agree to meet the financial and service commitments outlined. Further, I (we) agree to abide by the guidelines established in the school handbook and recognize that failure to do so could result in dismissal.

_____	_____
Parent or Guardian Signature	Date

_____	_____
Parent or Guardian Signature	Date