

Our Lady Help of Christians Academy

Date _____

CHILD'S LAST NAME	FIRST NAME	MIDDLE NAME	AGE	BIRTHDATE	<input type="checkbox"/> M <input type="checkbox"/> F
STREET ADDRESS		CITY	ZIP CODE	PHONE NO.	

Parent Status

Married
 Divorced
 Separated
 Deceased

Custodian: Mother Father
 Child with Mother Father
 Mother Father

Father		Mother	
NAME	AGE	NAME	AGE
EMPLOYER	WORK PHONE	EMPLOYER	WORK PHONE
HOME ADDRESS	HOME PHONE	HOME ADDRESS	HOME PHONE
CITY	ZIP CODE	CITY	ZIP CODE
CELL PHONE AND/OR E-MAIL ADDRESS		CELL PHONE AND/OR E-MAIL ADDRESS	

Emergency Information

PERSON TO BE CALLED IF PARENTS CAN'T BE REACHED	RELATIONSHIP	HOME PHONE	WORK PHONE
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Medical

FAMILY DOCTOR	ADDRESS	PHONE
PREFERRED HOSPITAL	ADDRESS	PHONE

In the event of accident, injury, or illness when I (we) cannot be reached, I (we) authorize *Our Lady Help of Christians Academy* to obtain whatever medical treatment deemed necessary and prudent to ensure the life and health of my (our) child.

Yes, I (we) authorize *Our Lady Help of Christians* staff to administer Acetaminophin (Tylenol) or Ibuprofen (Advil) when necessary to relieve pain.

No, do not administer pain relievers to my child.

DATE _____ SIGNED — PARENT OR LEGAL GUARDIAN _____

Please check the grade level in which you intend to enroll your child:

K
 1st
 2nd
 3rd
 4th
 5th
 6th
 7th
 8th
 9th
 10th
 11th
 12th

Required Forms:
THE FOLLOWING FORMS MUST ACCOMPANY YOUR CHILD on the first day of school. All except the immunization record and emergency information form will be returned to you after being recorded by *Our Lady Help of Christians Academy*.

<input type="checkbox"/> Birth Certificate*	<input type="checkbox"/> First Communion Certificate* *These will be returned.
<input type="checkbox"/> Baptismal Certificate*	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Confirmation Certificate*	<input type="checkbox"/> Emergency Information Form

History

Please list previous schools your child has attended. Please attach a separate sheet if you need more room.

School	Location	Dates Attended	Grade(s)
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Does your child have any behavioral or physical difficulties? If yes, please explain. _____

What forms of control are most effective in the home? _____

Does your child have any learning or academic difficulties? If yes, please explain. _____

Has your child been suspended or been asked to leave any school? If yes, please explain. _____

Please list language(s) spoken in the home. _____

Please list other siblings or adults living in the home and their age(s). Please include on separate attachment if you need more room.

Name	Relationship	Age
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Please list name(s) and phone number(s) of person(s) or facility in charge of your child after school.

Name	Phone No.
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Please list names of those people who may pick up your child after school.

Name	Relationship	Phone No.
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