BISHOP CARROLL CATHOLIC HIGH SCHOOL
Registration Form - 2016-2017

Class/Year of Graduation

(Name) Last First Middle

Mailing Address

Street Address (if different than mailing address)

City State Zip Code

Gender – ( ) Male ( ) Female

Home Phone Number

Ethnicity: ☐ African-American ☐ American Indian ☐ Hispanic
☐ Asian ☐ Caucasian ☐ Multi-Racial
☐ Other _____

Public School District

Birthdate Birthplace City State

Elementary School City

RELIGIOUS STATUS:

☐ Roman Catholic _____
Parish Town

☐ Non-Roman Rite _____
Parish Town

☐ Other (Specify) _____

Brothers/Sisters attending B.C. for the 2016-2017 school year:

First Name Grade

First Name Grade

Brothers/Sisters attending Catholic Grade Schools for the 2015-2016 school year:

First Name Grade School

First Name Grade School

☐ Living ☐ Deceased

Father's Name

e-mail address Occupation

Employer Employer Phone Number

Father's cell # _____

☐ Living ☐ Deceased

Mother's Name

e-mail address Occupation

Employer Employer Phone Number

Mother's cell # _____

Parental Status: ☐ Married ☐ Divorced ☐ Single
☐ Separated ☐ Widowed

Student Lives With: ☐ Parents ☐ Mother
☐ Father ☐ Guardian

Guardian e-mail address

Person to contact in case of emergency Relationship Phone
emergency if parents cannot be reached

Person to contact in case of disciplinary action Phone

Father's Signature **Mother's Signature**

2016-2017 Emergency Procedure Card

(Please Print in Blue or Black Ink)

Grade _____

Pupil's Full Name _____ **Date of Birth** _____
Last First Middle

Home Address _____

Home Phone _____ **Father's Cell #**_____ **Mother's Cell #**_____

Father's Full Name _____ **Employer** _____ **Work Phone** _____

Mother's Name _____ **Employer** _____ **Work Phone** _____

Custody papers have been provided and are on file at the school. ☐ **Yes** ☐ **No**

The following individuals may NOT remove my child from the school. Name _____ **Name** _____

Family Physician _____ **Address**_____ **Phone** _____

If Emergency treatment is required can the school authorities use their own judgement in sending the child to the hospital or doctor most accessible before the parents are reached? ☐ **Yes** ☐ **No**

If "No" Name preferred Hospital _____ **Preferred Physician** _____

In my absence the following persons are authorized to act for me in the above respect in behalf of my child.

1. _____
Name Relationship Address Phone

2. _____
Name Relationship Address Phone

I give my permission for health information on this card to be shared with teachers and staff. ☐ **Yes** ☐ **No**

List anything about the physical health of the student that the school should know. _____

Does your child have an allergy to any foods, medications, insects, latex or other substances? ☐ **Yes** ☐ **No**

If yes, please list in detail. _____

Please check if the allergy is ☐ **Severe** ☐ **Moderate** ☐ **Mild** **List symptoms:** _____

What medications or treatment is used to treat the allergy? _____

Has your child ever had a severe "anaphylactic" reaction requiring emergency care? ☐ **Yes** ☐ **No** **Most Recent Date:** _____/_____/_____

Ambulance Service ☐ **Yes** ☐ **No** **Name of Ambulance Service:** _____ **Phone Number:** _____

_____
Written Signature of Parent or Guardian