Immaculate Conception School

452 Bow Street
Elkton, MD 21921
www.icschoolweb.org
410-398-2636

Application must be accompanied by $100 nonrefundable registration fee and copy of the student's <u>Birth Certificate</u> and <u>Baptismal Certificate</u>* *(*if not baptized at Immaculate Conception/St. Jude Parish)*

Student Name ______________________________ Date of Birth ______________ Entering Grade ___

If entering PK, please indicate preferred schedule:

Five full days___ (M-F; 8:00am-2:00pm); three full days ___ (M, W, F; 8:00am – 2:00 pm); five half days ___ (M-F, 8:00a.m – 11:00am)

Parish ____________________ Ethnicity __________ M F Student resides with: ____________________

Address ______________________________ City ______________ State _____ Zip __________

Development/Area ____________________ Home Phone ____________________ Religion ____________________

Guardian E-mail address ____

Parent's marital status (please circle): married separated divorced mother remarried father remarried

Mother's Name ______________________________ Employer ______________________________

Title/Position/Occupation ____________________ Work Phone ______________ Cell Phone ______________

Father's Name ______________________________ Employer ______________________________

Title/Position/Occupation ____________________ Work Phone ______________ Cell Phone ______________

Step Parent Name ______________________________ Employer ______________________________

Title/Position/Occupation ____________________ Work Phone ______________ Cell Phone ______________

School district student resides in: ______________________________ County ____________________

Previous/Present School ____

School Name Address

Reason for leaving ____

Please list your child's sacraments:

Sacraments	Date Received	Church	City and State
Baptism	______________	______________	______________
Reconciliation	______________	______________	______________
First Communion	______________	______________	______________
Confirmation	______________	______________	______________

Beginning with the oldest child please list children in family (including this child)

	Birth Date	First Name	Religion	School Attending	Present Grade
1.	__________	______________	________	______________	______
2.	__________	______________	________	______________	______
3.	__________	______________	________	______________	______
4.	__________	______________	________	______________	______

Emergency contact #1 (other than parents): Name ______________________________ Relationship ____________________

Phone number ____________________________ (circle one) cell home work

Emergency contact #2 (other than parents): Name ______________________________ Relationship ____________________

Phone number ____________________________ (circle one) cell home work

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HEALTH:

Doctor ____________________________ Address ____ Phone __________________

Dentist ____________________________ Address ____ Phone __________________

Ins. Co. ____ Policy holders name _______________________________________

Policy # ____ Group # ____

- Has your child had any of the following?

Allergies	_____	Head Injury	_____	Mononucleosis	_____	Tonsillitis	_____
Asthma	_____	Hearing Condition	_____	Mumps	_____	Leukemia	_____
Blood Disorder	_____	Heart Condition	_____	Pneumonia	_____	Strep Throat	_____
Broken bones	_____	Hernia	_____	Repeated Colds	_____	Vision Defect	_____
Chicken Pox (date)	_____	Hyperactivity	_____	Scarlet Fever	_____	Ear Infection	_____
Kidney Disorder	_____	Seizure Disorder	_____	Whooping Cough	_____	Tumor	_____
Tuberculosis Contact	_____						

Is your child receiving medical treatment currently? **Yes___ No___** If yes, why? ______________________________
____

Does your child wear glasses, hearing aid, or other appliances? **Yes ___ No ___** If yes, please describe______________
____

Is your child restricted from physical activity? **Yes___ No___** If yes, please describe restriction
____

List allergies & reaction ____

Does your child require medication for these allergies? **Yes___ No___**

List any medications your child is currently taking ____

(If any medication is to be dispensed at school, a medical dispensing form needs to be signed by physican and parent)

Please list injuries/diseases/operations this child has had, and when they occurred ___________________________

____

Other physical disabilities and/or medical conditions the school should be aware of ____________________________

____

In case of an emergency illness or accident to the child named above, the school is authorized to proceed as indicated above or as the school sees fit in an emergency.

Parent/Guardian Signature ____ **Date** ______________________