

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 Baptismal Certificate and Birth Certificate****

Student Name _____ Date of Birth _____ Entering Grade _____

Parish _____ Ethnicity _____ M F Student resides with: _____

Address _____ City _____ State _____ Zip _____

Development/Area _____ Home Phone _____ Religion _____

Guardian E-mail address(es) _____

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

Emergency contact #3 (other than parents): Name _____ Relationship _____

Phone number _____ (circle one) cell home work

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 _____			

Please circle if any of the following apply:

Instrumental delivery Cesarean section oxygen therapy premature or incubator at birth

Is your child receiving medical treatment currently? Yes No If yes, why? _____

Does your child wear glasses, hearing aid, or other appliances? _____

Is your child restricted from physical activity? Y N If yes, 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.)

Please list injuries/diseases/operations 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 _____