REGISTRATION INFORMATION

St Rose St Mary's School
140 Auto Street • Clintonville, WI 54929 • 715-201-9913

STUDENT who will be *Sharing the SPIRIT* _____
Last First Middle

Grade Entering _____ Gender _____ Parish Membership _____

Place of Birth _____ Birth Date _____
City State Month/ Day / Year

Race: ___ Caucasian ___ African American ___Hispanic ___American Indian/Alaskan Native ___Asian ___ Other

Previous School _____
Name City State

Home Address _____
Street City State/Zip Code

If Different
Mailing Address _____
Street City State/Zip Code

County of Residence _____ Home public school district _____

Primary Contact Person for this Student _____

Preferred Phone Number _____(home/cell/work)

Email Address _____@_____

Father/Guardian Name _____Religion _____

Employer _____ Working Hours _____

Work Phone _____ □ I can be contacted at work

Cell Phone_____ Email _____

Mother/Guardian Name _____Religion _____

Employer _____ Working Hours _____

Work Phone _____ □ I can be contacted at work

Cell Phone_____ Email _____

Marital Status of Parents: □Married □Single □Widowed □Divorced □Separated

Custodial Parent _____

Step Father _____Step Mother _____

SIBLINGS

Name	Gender	Birth Date
Name	Gender	Birth Date
Name	Gender	Birth Date

STUDENT who will be *Sharing the SPIRIT* _____

BAPTISM

Parish | City/State | REQUIRED: Month/ Day/ Year

FIRST RECONCILIATION

Parish | City/State | REQUIRED: Month/ Day/ Year

FIRST EUCHARIST

Parish | City/State | REQUIRED: Month/ Day/ Year

BAPTISMAL CERTIFICATE ON FILE WITH ST ROSE ST MARY'S SCHOOL? _____Yes _____No

HEALTH HISTORY (Check all that apply)

□ Asthma	□Respiratory	□Migraines	□Diabetes	□Hearing Impairment
□Heart	□Bleeding Disorders	□Seizures	□Surgery	□Physical Handicap
□Kidney/Bladder	□Cancer	□Arthritis	□Sight Impairment	□Other

Please explain any boxes checked _____

_____

_____

ALLERGIES

□ Drug Allergies - List _____

□ Food Allergies - List _____

□ Bee Sting _____

EMERGENCY CONTACT(S) if parent/guardian is not available

NAME _____ Relationship _____

Home phone _____ Cell _____ Work _____

NAME _____ Relationship _____

Home phone _____ Cell _____ Work _____

FAMILY PHYSICIAN _____ Phone _____

Clinic and Address _____

DENTIST _____ Phone _____

OPTOMETRIST _____ Phone _____

STUDENT'S NORMAL TRANSPORTATION TO/FROM SCHOOL

Coming to School:	□ Bus	□ Private Car	□ Walk
Going Home:	□ Bus	□ Private Car	□ Walk

Parent/Guardian who completed this form (Please print) _____

SIGNATURE _____ Date _____