Bishop John King Mussio Central Elementary School
K-5 Registration Form

*Entering Grade*_____ *Assigned Homeroom*______

Student Name____
(Last) (First) (Middle)

Address____
(Street) (City) (State) (Zip Code)

Home Phone Number________________________Family E-Mail Address_________________________________

Birthdate______________________Gender________________Social Security Number______________________

Religion ______________________Student's Parish______________________________________

Sacraments Received:

Baptism (**Church**)______________________________**(City & State)**______________________**(Date)**___________

First Communion (**Church**)__________________________**(City & State)**______________________**(Date)**___________

Confirmation (**Church**)____________________________**(City & State)**______________________**(Date)**___________

Public School **District** in which student resides____

Name of Public School **Building** nearest student's home address_________________________________

ETHNIC GROUP (Please select only one)

_____*American Indian/Alaskan Native* (person having origins in any of original peoples of N America and maintains cultural identification through tribal affiliation or community recognition

_____*Asian* (person having origins in any one of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent)

_____*Hispanic* (persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race)

_____*Black, not Hispanic origin* (a person having origins in any of the Black racial groups of Africa)

_____*Native Hawaiian/Other Pacific Islander* (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island

_____*Multiracial* (a person having origins in two or more racial/ethnic categories)

_____*White, not Hispanic origin* (a person having origins in any of the original peoples of Europe, North Africa or the Middle East

School Previously Attended_______________________________ Dates__________Grade Completed__________

Father's Name____Occupation_______________________
(Last) (First) (Title)

Religion______________________Parish_______________________ Employer__________________________

Home Phone___________________Cell Phone_________________Work Phone_______________________

Mother's Name____Occupation______________________
(Last) (First) (Title) (Maiden)

Religion______________________Parish _______________________Employer___________________________

Home Phone___________________Cell Phone_________________Work Phone____________________

Whom does student live with? (Please circle): Mother & Father, Mother only, Mother and Stepfather, Father only, Father & Stepmother, Guardian

Parent or Guardian Signature____Date____________________

Copies needed for complete registration:

_____Official Birth Certificate

_____Social Security Card

_____Baptism Certificate

_____Immunization Record

_____$50 Registration Fee **for new families to BJKM**

(Over please)

Sibling Information (Please list all siblings in the family)

Name	Age	Grade	School

The following information must be provided if the enrolling student ***lives with*** a guardian or stepparent:

Stepparent
Name____
(Last) (First)

Home Phone__________________Work Phone____________________Cell Phone__________________

Guardian
Name____
(Last) (First)

Home Phone__________________Work Phone____________________Cell Phone__________________

Bishop John King Mussio Central Elementary School

K-5 Health Record

Child's Name____ M___ F___

Date of Birth________________

Physician ________________________________Phone ____________

PAST MEDICAL HISTORY

Hospitalizations____

Surgeries____

Chicken Pox YES NO Date__________

Seizure Disorder YES NO if yes, please explain____________________

CURRENT MEDICAL HISTORY

Asthma (please circle) YES NO Medications__________________ Inhalers__________

Allergies____________________ What type of reaction____________________

Bee Stings____________________ What kind of reaction____________________

Current Health Conditions____

Current Medications ____

Prescribed medication that needs administered during school requires a form to be completed by the physician

Frequent Colds YES NO

Frequent Sore Throats YES NO

Hearing Difficulties YES NO

Vision Difficulties YES NO

Frequent Ear Infections YES NO

Frequent Stomach Aches YES NO

Speech Problems YES NO

Wear Glasses YES NO

Name of Eye Specialist____________________ Date of Last Exam ____________

Physical limitations ____

PLEASE ATTACH IMMUNIZATION RECORD TO THE BACK OF THIS FORM