

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

Entering Grade \_\_\_\_\_ Assigned Homeroom \_\_\_\_\_

Student Name \_\_\_\_\_

Address \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle)

\_\_\_\_\_ (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 Ear Infections YES NO

Frequent Sore Throats YES NO

Frequent Stomach Aches YES NO

Hearing Difficulties YES NO

Speech Problems YES NO

Vision Difficulties 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***