Bishop John King Mussio Central Elementary School
K-6 Registration Form

*Entering Grade*_____ *Assigned Homeroom* _____

Student Name_____
(Last) (First) (Middle)

Address_____
(Street) (City) (State) (Zip Code)

Home Phone Number _____ Cell Number_____ E-Mail _____

Birthdate _____ Gender _____ Social Security Number _____

Religion _____ Student's Parish _____

Sacraments Received:

Baptism (church and date)_____ _____

First Communion (church and date)_____ _____

Confirmation (church and date)_____ _____

Public School **District** in which student resides_____

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

School Previously Attended _____Grade _____Date _____

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

Religion _____ Parish _____ Employer_____

Home Phone _____ Cell Phone _____ Email _____

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

Religion_____ Parish _____ Employer_____

Home Phone_____ Cell Phone_____ Email_____

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

*Parent or Guardian Signature*_____Date_____

Sibling Information (Please list all siblings in the family)

Name	School	Grade	Age

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

Stepparent Name_____
(Last) (First) (Title)

Home Phone_____ Cell Phone_____ Email _____

Guardian Name_____
(Last) (First) (Title)

Home Phone_____ Cell Phone_____ Email _____

Copies needed for complete registration:

_____ *Official* Birth Certificate
_____ Social Security Card
_____ Baptismal Certificate
_____ Immunization Record
_____ $50 Registration Fee for new BJKM Families

03/2026

Bishop John King Mussio Central Elementary School
K-6 Health Record

Child's Name_______

Gender _____ 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