

\_\_\_\_\_

Today's Date

# Saint Bernard Catholic School Admissions Application

\_\_\_\_\_

Family Last Name

## STUDENT INFORMATION

Full (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ Previous School \_\_\_\_\_  
Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Ethnicity \_\_\_\_\_ SSN \_\_\_\_\_ Grade at Enrollment \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Home Parish/Church \_\_\_\_\_

### *For Office Use Only:*

STN \_\_\_\_\_ Birth Certificate? \_\_\_\_\_ Immunization Record? \_\_\_\_\_ Bus Numbers: A.M. \_\_\_\_\_  
Date Enrolled \_\_\_\_\_ Baptismal Record? \_\_\_\_\_ P.M. \_\_\_\_\_

## FAMILY INFORMATION

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_ Custody:  Legal  Physical  
Address, if different \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
Stepmother's Name, *if applicable* \_\_\_\_\_ Her Phone Number \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_ Custody:  Legal  Physical  
Address, if different \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
Stepfather's Name, *if applicable* \_\_\_\_\_ His Phone Number \_\_\_\_\_

### Siblings not at Saint Bernard:

Name \_\_\_\_\_ Age \_\_\_\_\_ School Attending \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY CONTACT INFORMATION *(not in your immediate household, available during the day)*

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## SPECIAL SERVICES REQUIRED *(check all that apply)*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Speech/Language   | <input type="checkbox"/> Autism                  | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Other Special Needs |
| <input type="checkbox"/> LD                | <input type="checkbox"/> Other Health Impaired   | <input type="checkbox"/> Emotional Handicap     | <input type="checkbox"/> Title I             |
| <input type="checkbox"/> Hearing Impaired  | <input type="checkbox"/> Dual Sensory Impairment | <input type="checkbox"/> Multiple Handicaps     | <input type="checkbox"/> 504                 |
| <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Orthopedic Impairment   | <input type="checkbox"/> Mental Handicap        | <input type="checkbox"/> Gifted/Talented     |