

# St. Matthew Registration Application

Date:	Grade Entering:	U.S. Citizen	Y	N	Gender:	B	G	Number of boys:
Student Name:	Home Phone:							Number of girls:
Date of Birth:	Language spoken at home:							This number child:
Address:	Student's religion:				Church Attending:			
(zip)	Public School which student would attend:				School District:			
Father:	Marital Status:				Occupation:	Student Ethnicity:		
Father's Address:	Zip:				Dad's Cell #:	Anglo		
Father's E-mail:	Dad's Home #:				Dad's Work #:	Asian		
Mother:	Marital Status:				Religion:	Bi_Racial		
Mother's Address:	Zip:				Mom's Cell #:	Hispanic		
Mother's E-mail:	Mom's Home #:				Mom's Work #:	Native American		
						Other		

**IF PARENTS ARE DIVORCED, A COPY OF THE CUSTODY DECREE MUST BE ON FILE IN THE SCHOOL OFFICE.**

Step Father: Address if different from student: Cell #: Work #:

Step Mother: Address if different from student: Cell #: Work #:

How did you hear about St. Matthew?

What is your main reason for choosing St. Matthew?

Has the applicant ever been suspended or dismissed from any school? If Yes (Reason)

Please indicate any special circumstances that may have interrupted or affected the applicant's performance in school.

Does the applicant have any clinically diagnosed learning differences (speech/language therapy, resource classes, counseling, ADHD, ADD, Dyslexia, etc.) or physical disabilities? Yes No Has the applicant ever been on medication for educational purposes? Yes No

(The school must be provided with documentation in order for accommodations to be made). The school nurse needs to be aware of any medication the student is taking.

I attest that the information listed above is true to the best of my knowledge and that any misrepresentation of facts on this application may result in denial or revocation of admission.

Parent Signature: Date:

## HEALTH FORM

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The Archdiocese of San Antonio is not accepting affidavits/exemptions for the reasons of conscience, including a religious belief.

Immunization requirements: Students must be in compliance with all required immunizations as set forth by the Texas Department of State Health Services, Immunization Division. [www.immunizetexas.com](http://www.immunizetexas.com)

Children will be screened as set forth by the Texas Department of State Health Services for hearing, vision, scoliosis and Acanthosis nigricans. The school will follow the required screening schedule.

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

### **PHYSICAL HISTORY**

**YEAR**

Accident-Serious \_\_\_\_\_

Allergy\* - Drug/Other \_\_\_\_\_

Asthma\* \_\_\_\_\_

Blood Disorder \_\_\_\_\_

Cardiac Disease/Problem \_\_\_\_\_

Chicken Pox (date required) \_\_\_\_\_

Congenital Deformity \_\_\_\_\_

Diabetes \_\_\_\_\_

Hypertension \_\_\_\_\_

Illness - Serious \_\_\_\_\_

Scarlet Fever \_\_\_\_\_

Neurological Disorder \_\_\_\_\_

Otitis Media (Ear Infection) \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Seizure Disorder (Epilepsy)\*\* \_\_\_\_\_

Surgery\*\*- Serious \_\_\_\_\_

TB Contact \_\_\_\_\_

Urinary Problem \_\_\_\_\_

Vision Loss \_\_\_\_\_

Daily Medication \_\_\_\_\_

**INJURIES**

Head\*\* \_\_\_\_\_

Back\*\* \_\_\_\_\_

**COMMENT(S)** \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\* Please indicate an "M" for moderate or an "S" for severe.

\*\* Details needed, please use COMMENTS section