

ST. MICHAEL'S CATHOLIC SCHOOL
West Memphis, Arkansas

STUDENT ENROLLMENT APPLICATION

A child entering must be of age for the Preschool or Kindergarten grade level on or before September 1.

**** Please Print ****

Today's Date _____ Elementary Grade applying for _____ Preschool 3 or 4

STUDENT INFORMATION

Name

Last First Middle Preferred Name

Address _____
No. Street Apt# City State ZIP

Birth Date _____ Birthplace _____ Home Phone _____

Religion _____ Parish/Church _____

Baptism Date _____ Church & Address _____

Reconciliation Date _____ Church & Address _____

Communion _____ Church & Address _____

Languages spoken in the home English ___ Spanish ___ Other (specify) _____

Does your child have any medical issues that we need to know about? Yes ___ No ___

If yes, please explain _____

Has your child ever been evaluated for any special needs? IEP's, 504 plan, etc. Yes ___ No ___

Has your child ever been diagnosed with: ADD ___ LD ___ ADHD ___ Dyslexia ___ Other _____

ASD ___ Speech Impairment ___ Hearing Impairment ___

Is your child receiving any educational assistance or support services at this time? Yes ___ No ___

If yes, please explain _____

Has your child previously applied or been enrolled at St. Michael's Catholic School? Yes ___ No ___

Did your child attend a Catholic School or Religious Ed. Program last year? Yes ___ at _____
No ___

Please share with us why you wish to apply to St. Michael's Catholic School: _____

Check all applicable: Lives with both parents Lives w/Mother Lives w/Father
 Lives w/Guardians Parents divorced Parents separated
 Mother deceased Father deceased Mother remarried Father remarried

Other _____

UNLESS WE HAVE COURT RECORDS ON FILE THAT STATE OTHERWISE, BOTH PARENTS HAVE ACCESS TO THE STUDENT AND ALL OF HIS/HER EDUCATION RECORDS

SIBLINGS	AGE/GRADE	SCHOOL ATTENDING
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Present School _____ Reason for Leaving _____

Address _____
 No. Street Apt# City State ZIP

Parent Signature _____ Date _____

Parent Signature _____ Date _____

ST. MICHAEL'S CATHOLIC SCHOOL
EMERGENCY INFORMATION SHEET

Last Name	Father	Mother
Student's Name	Student's Name	Student's Name
Mother's email _____	Father's email _____	
Mother's Employment _____	Father's employment _____	
Phone# _____	Phone# _____	
Position _____	Position _____	
Cell Phone # _____	Cell Phone # _____	

* Please put an asterisk by the email address to be used as the primary for school contact *

List a friend or relative who will assume care of your child if you cannot be reached in an emergency.

Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

Child's Name _____	Allergies _____
Child's Name _____	Allergies _____
Child's Name _____	Allergies _____
Other conditions _____	
Daily Medication _____	Dosage _____

Physician _____

Address _____

Physician's Office Phone _____

In case of serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician listed and follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary including transportation of my child.

Signature of Parent/Guardian _____ Date _____

ST. MICHAEL'S CATHOLIC SCHOOL

Pickup Information

Student Name

Student Name

Student Name

Student Name

My children are in a carpool with _____

The following individuals have my permission to pick my child up from school.

1. Name _____ Relationship _____

Phone Number _____

2. Name _____ Relationship _____

Phone Number _____

3. Name _____ Relationship _____

Phone Number _____

_____ My child(ren) will be in after school care on _____
Mon Tue Wed Thur Fri

All children not picked up by 3:15 are sent to After School Care and the current drop-in rate is applied.

AFTER SCHOOL CHARGES

3:15-4:00 \$2.00

4:00-5:00 \$5.00

5:00-6:00 \$8.00

½ PRICE FOR EACH ADDITIONAL CHILD PER FAMILY

After School will be billed monthly

Parent/Guardian Signature _____ Date _____

ST. MICHAEL'S CATHOLIC SCHOOL

Tuition Agreement Form / Direct Draft Authorization Form

Family Name _____

The draft for tuition will begin:

Amount of:

10th of the month for 12 months
(beginning on June 10 and ending on May 10)

25th of the month for 10 month
(beginning on August 25 and ending May 25)

15th of the month (pay in office)

Annually with 5% discount (due by Labor Day)

Name on the account _____

Bank or Institution _____

Routing Number _____

Account Number _____

Authorized Signature responsible for payments _____

I authorize St. Michael's Catholic School to instruct my bank to draft my account for the tuition amount indicated above. The information is to be solely for the purpose of consumer withdrawal.

Authorized Signature responsible for payments _____

Date _____

By signing this agreement I agree to be the responsible party. I accept and agree to be bound by the terms and conditions of the agreement.