

IMPORTANT INFORMATION

Name of Church Attending:		
Is Child Baptized:	Where and when:	
Doctor:	Dentist:	Hospital of choice:
Health Insurance Co:		
Name of Policy Holder:		
<i>LIST ANY SPECIAL INSTRUCTIONS REGARDING MEDICAL PROBLEMS, ALLERGIES, MEDICATIONS, ETC.</i>		
School District of Residence:		
Last School Attended:	City/State:	
Has your child ever been: Retained: _____ Expelled: _____ Suspended: _____		
If yes, please describe:		
Names & ages of other children in the home:		

EMERGENCY & PICK UP INFORMATION

After school, my child(ren) will be: <i>(Please circle one for each day, Pick Up or Bus)</i>		
Mon - P/U or Bus - Tue - P/U or Bus - Wed - P/U or Bus - Thur - P/U or Bus - Fri - P/U or Bus		
The following persons may act on our behalf if the parents cannot be reached:		
_____	_____	_____
Name	Relationship to Student(s)	Phone #
_____	_____	_____
Name	Relationship to Student(s)	Phone #
The following individuals may pick up my children from school.		
_____	_____	_____
Name	Relationship to Student(s)	Phone #
_____	_____	_____
Name	Relationship to Student(s)	Phone #

ST. PAUL LUTHERAN SCHOOL

Parent / School Agreement

- I understand that the school offers an educational experience based on Christian principles and values. I agree to support the Christian mission of St. Paul Lutheran Church and understand that my child will be taught from a Lutheran Christian world view.

- I will support school policies regarding codes of conduct, dress code, discipline and nutrition.

- I will notify the school the morning my child is absent.

- In the event my child becomes ill or is injured while under school supervision, I authorize the school authorities to take the following steps:

> Contact a parent of the student and follow his/her instructions.

> In the event that neither parent can be reached, contact the student's physician and follow his/her instructions.

911 will be called if school personnel deem it necessary.

> I authorize the medical facility and/or physician to provide and perform treatment as deemed necessary by the physician.

> I accept all responsibility for payment for any and all medical services rendered under this authorization.

> Further, I released the principal or her/his designee, St. Paul Lutheran School and/or St. Paul Lutheran Church from any and all liability which might arise from the granting of such authorization, it being my desire that my child be furnished with such medical or surgical services as soon as reasonably possible after the need arises.

- I understand and accept my responsibility to pay the tuition that is due each month. I understand the policy on non-refundable and non-transferable fees and withdrawal procedures. I understand that my child will not be permitted to attend classes if my account is 45 days or more in arrears; and accept that records and reports will not be released until all financial obligations to St. Paul Lutheran School have been fulfilled.

Principal Signature: _____

Parent / Guardian Signature: _____

Date: _____

*The mission of St. Paul Lutheran School is to enable the families of the community
to know Jesus as their Savior by providing
a Christian educational environment which fosters academic excellence.*

PHOTO AUTHORIZATION

I hereby give permission for my child's photograph to be published by St. Paul Lutheran School as part of its promotional and advertising publications. This includes, but is not limited to, internet, print and electronic media. I understand that no addresses will be affixed to the photos.

This applies to any promotional materials produced during the current school year and summer to follow.

_____ Yes _____ No Signature: _____

NOTES

For Office Use Only:	GRADE: _____ START DATE: _____
<u>Forms Required Below</u>	TRANSFER: _____ RECORDS: Academic _____ Health _____
BC: _____ SSC: _____	REG FEE PD: \$ _____ Ck #/Cash _____
Immunization: _____	BISON: \$ _____ T/A: \$ _____ SP/GRNT: \$ _____
T/A APP: _____	PAYMENT AGREEMENT: \$ _____



**REGISTRATION FORM
2022-2023
ST. PAUL LUTHERAN SCHOOL**

STUDENT INFORMATION

Student's Full Name: _____

Grade: (please circle) 3 day-PreK 5 day-PreK K 1 2 3 4 5 6

New Student:* _____ Returning Student: _____ If returning student, go to next box and fill out rest of form

Permanent Address: _____

City/State/Zip: _____

School District Student Resides In: _____

Phone: () _____ Sex: _____ DOB: ____/____/____

Social Security #: ____/____/____ Birthplace: _____

* New Students: We will need a copy of their birth certificate, social security card & immunization record.

PARENT INFORMATION

Father's Name: _____

Same Address: _____ If no, _____

Mother's Name: _____

Same Address: _____ If no, _____

Student lives with: Both parents: _____ Mother: _____ Father: _____ Other: _____

Father's Employer: _____ Phone #: (____) _____

Address: _____ Cell/Pager: (____) _____

Mother's Employer: _____ Phone #: (____) _____

Address: _____ Cell/Pager: (____) _____

Email Address: _____

Your contact information may be published in Roster shared with School Families: _____ Yes _____ No