



Mount St. Michael Catholic School ~ Family Registration Form

Mail: P.O. Box 225159, Dallas, TX 75222-5159 ~ Physical: 4500 W. Davis, Dallas, TX 75211

Phone: 214-337-0244 ~ Fax: 214-339-1702 ~ Email: info@msmcatholic.org

Complete information in the 1st column. Write information that is different from the 1st column in the additional columns.

	Father, Custodial Parent, or Legal Guardian	Mother, Other Custodial Parent, or Legal Guardian	Other involved adult (e.g. step-parent)	Other involved adult (e.g. step-parent)
Salutation: Dr., Miss, Mr. Mrs., Ms.				
Last Name				
First Name				
Middle Name				
Name Preferred to be called				
Home Address Street				
Home Address City, State, Zip				
Relation to children				
Marital Status				
Religion				
Parish				
Christian Community of God's Delight Member	Yes No	Yes No	Yes No	Yes No
Home Phone				
Cell Phone				
Work Phone				
Email				
Occupation				
Company				
Work Address Street				
Work Address City, State, Zip				
Check all that apply	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased

Please complete even if grandparents live out of town so we can send cards and children's artwork.

	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Salutation: Dr., Miss, Mr. Mrs., Ms.				
Last Name				
First Name				
Middle Name				
Name Preferred to be called				
Home Address Street				
Home Address City, State, Zip				
Relation to children				
Marital Status				
Religion				
Home Phone				
Cell Phone				
Work Phone				
Email				
Check all that apply	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased	<input type="checkbox"/> Custodial <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Correspondence <input type="checkbox"/> Financial Responsibility <input type="checkbox"/> Deceased

List two people/families who will assume temporary care of your child if you cannot be reached.

1. Name _____ Relationship to children _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

2. Name _____ Relationship to children _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

Complete information in the 1st column. Write information that is different from the 1st column in the additional columns.

Last Name			
First Name			
Middle Name			
Name Preferred to be called			
Birthdate			
Gender (circle one)	Male Female	Male Female	Male Female
Ethnicity			
Grade for 08-09 (circle 1 per child)	3K ½ day for 4 or 5 days 3K full day for 4, or 5 days 4K ½ day for 4 or 5 days 4K full for 4 or 5 days K, 1, 2, 3, 4, 5, 6, 7, 8	3K ½ day for 4 or 5 days 3K full day for 4, or 5 days 4K ½ day for 4 or 5 days 4K full for 4 or 5 days K, 1, 2, 3, 4, 5, 6, 7, 8	3K ½ day for 4 or 5 days 3K full day for 4, or 5 days 4K ½ day for 4 or 5 days 4K full for 4 or 5 days K, 1, 2, 3, 4, 5, 6, 7, 8
Language Spoken at Home			
Citizenship			
Physical Conditions (Check all that apply)	<input type="checkbox"/> Visual impairment <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Heart Disease <input type="checkbox"/> Orthopedic handicap <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Braces/Retainer <input type="checkbox"/> Allergies <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Visual impairment <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Heart Disease <input type="checkbox"/> Orthopedic handicap <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Braces/Retainer <input type="checkbox"/> Allergies <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Visual impairment <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Heart Disease <input type="checkbox"/> Orthopedic handicap <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Braces/Retainer <input type="checkbox"/> Allergies <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Other: (specify)
Additional comments about child's health			
Birthplace City, County, State, Country			
Previous School Name			
Previous School Street Address			
Previous School Name City, State, Zip			

Complete information in the 1st column. Write information that is different from the 1st column in the additional columns.

Last Name			
First Name			
Middle Name			
Name Preferred to be called			
Birthdate			
Gender (circle one)	Male Female	Male Female	Male Female
Ethnicity			
Grade for 08-09 (circle 1 per child)	3K ½ day for 4 or 5 days 3K full day for 4, or 5 days 4K ½ day for 4 or 5 days 4K full for 4 or 5 days K, 1, 2, 3, 4, 5, 6, 7, 8	3K ½ day for 4 or 5 days 3K full day for 4, or 5 days 4K ½ day for 4 or 5 days 4K full for 4 or 5 days K, 1, 2, 3, 4, 5, 6, 7, 8	3K ½ day for 4 or 5 days 3K full day for 4, or 5 days 4K ½ day for 4 or 5 days 4K full for 4 or 5 days K, 1, 2, 3, 4, 5, 6, 7, 8
Language Spoken at Home			
Citizenship			
Physical Conditions (Circle all that apply)	<input type="checkbox"/> Visual impairment <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Heart Disease <input type="checkbox"/> Orthopedic handicap <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Braces/Retainer <input type="checkbox"/> Allergies <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Visual impairment <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Heart Disease <input type="checkbox"/> Orthopedic handicap <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Braces/Retainer <input type="checkbox"/> Allergies <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Visual impairment <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Heart Disease <input type="checkbox"/> Orthopedic handicap <input type="checkbox"/> Asthma/Hay Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Braces/Retainer <input type="checkbox"/> Allergies <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Other: (specify)
Additional comments about child's health			
Birthplace City, County, State, Country			
Previous School Name			
Previous School Street Address			
Previous School Name City, State, Zip			

Personal Data

This release gives permission for Mount St. Michael Catholic School to obtain confidential information that may affect your child's educational progress, including diagnostic evaluations, medications or specific family situations. Failure to disclose such pertinent data at any time during the school year may result in subsequent dismissal.

_____ Yes, I give permission to release this information to Mount St. Michael Catholic School.

_____ No, I do not give permission to release this information to Mount St. Michael Catholic School.

Parent's Signature _____ Date _____

Photos & Work Release

This release gives the school permission to publish photos, artwork, or written work that may include your child as part of publicity and/or advertising purposes. This release would also allow your child's work to be displayed on the official school website: www.msmcatholic.org or on the password protected www.renweb.com. Please check one of the following:

_____ Yes, my child's work/photo may be used for publicity and/or advertising for MSM.

_____ No, my child's work/photo may not be used for publicity and/or advertising for MSM.

Parent's Signature _____ Date _____