St. Joseph Catholic School System
Student Application Form · 2017-2018

Elementary Campus: 901 E. Wm. Joel Bryan Pkwy., Bryan, TX 77803 • Phone: 979-822-6643
Secondary Campus: 600 S. Coulter Dr., Bryan, TX 77803 • Phone: 979-822-6641
Fax: 979-779-2810 • www.stjosephschoolbcs.org

Registration Fees: $150 for returning students, $200 for new students, $1,000 for new international students.

Application Date: _____

Application for Grade: _____ (Families with multiple children may complete all but line one and make copies for each student.)

Student Information

Student's Name: _____
(Last) (First) (Middle)

Home Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Place of Birth: _____ Gender: _____

Ethnic Background: _____ Language spoken at home: _____

Religious Preference: _____ Church or Parish: _____

Parent Information

Student lives with: _____ Both Parents _____ Mother _____ Father _____ Guardian

Father's Name: _____ Home Phone #: _____ Cell #: _____

Home Address (if different from above): _____

Place of Work: _____ Work Phone: _____ E-mail: _____

Religious Preference: _____ Education (Highest): _____

Mother's Name: _____ Home Phone #: _____ Cell #: _____

Home Address (if different from above): _____

Place of Work: _____ Work Phone: _____ E-mail: _____

Religious Preference: _____ Education (Highest): _____

Guardian's Name: _____ Home Phone #: _____ Cell #: _____

Home Address (if different from above): _____

Place of Work: _____ Work Phone: _____ E-mail: _____

Religious Preference: _____ Education (Highest): _____

Previous Educational Affiliation

Has the student previously attended any other schools: _____ Yes _____ No

If yes, list which school the student last attended and when. _____

_____

Name of the public school student would attend. _____

Student Religious Information

	Baptism	First Reconciliation	First Communion	Confirmation
Date				
Church				
City & State				

Did your child attend instruction in the Catholic faith last year? _____ No _____Yes: _____RE _____ Catholic School

Medical History

Has your child had any of the following? Please indicate the approximate age at which he or she had, or was diagnosed with, the ailment.

_____ Measles (Rubcola-red-10days) _____ Measles (Rubella-German-3days) _____ Mumps _____ TB

_____ Chicken Pox _____ Scarlet Fever _____ Polio

Does your child have any of the following? Answer Yes or No

_____ Asthma _____ Allergies: ❑ Type 1-general dust mold or ❑ Type 2 Medications

_____ Diabetes _____ Heart Disease _____ Convulsions

_____ Kidney or Bladder Problems _____ ADD / ADHD _____Frequent Nose Bleeds

_____ Other (please specify) _____

Is the student on any medications? _____ Yes _____ No

If yes, please state: _____

Name of Medication: _____ Dosage: _____ When Taken: _____

For Office Use Only

Date form returned: _____

Check # _____ Amount: $_____