St. Aloysius School

33 South Avenue, New Canaan, CT 06840
Telephone: 203-966-0786 Fax: 203-972-6960

Check one:
____ New Family
____ Existing Family

Registration Form for Admission
2018-2019

Child 1: _____
(First Name) (Last Name) (M/F) (Grade Entering) (Date of Birth)

Child 2: _____
(First Name) (Last Name) (M/F) (Grade Entering) (Date of Birth)

Child 3: _____
(First Name) (Last Name) (M/F) (Grade Entering) (Date of Birth)

Mother/Guardian:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Employer: _____
Work Phone: _____
Occupation: _____

Father/Guardian:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Employer: _____
Work Phone: _____
Occupation: _____

Marital Status: _____ Student(s) lives with: ☐ Mother ☐ Father ☐ Grandparent ☐ Guardian ☐ Other: _____

Registered Parish (if applicable) :_____

EMERGENCY CONTACT INFORMATION: (Non-parent or Non-Guardian)

_____
(Name) (Daytime Phone) (Relationship)

_____
(Name) (Daytime Phone) (Relationship)

_____
(Name) (Daytime Phone) (Relationship)

SAFE ENVIRONMENT / VIRTUS

☐ I/We understand that to volunteer in any capacity at St. Aloysius School I/we must comply with the Diocese of Bridgeport and USCCB Safe Environment mandates that include VIRTUS training, consenting to a background check, and signing and submitting the Executive Summary for Lay Volunteers. Forms and further information is available in the school's main office.

PARENT/MEDICAL SIGN-OFF – AUTHORIZATION FOR MEDICAL CARE:

In the event of a medical emergency or illness, I hereby authorize St. Aloysius School to provide first aid, and/or to request emergency medical treatment and transportation to a hospital. Any hospital or emergency personnel are authorized to provide treatment to my child of such nature as they deem appropriate and to consult with the physician listed below. (Please sign below)

(Parent Signature): _____ (Date): _____

Child 1 Doctor:

Name: _____ Phone: _____

Child 2 Doctor:

Name: _____ Phone: _____

Child 3 Doctor:

Name: _____ Phone: _____

Child 1 Dentist:

Name: _____ Phone: _____

Child 2 Dentist:

Name: _____ Phone: _____

Child 3 Dentist:

Name: _____ Phone: _____

LIST HEALTH ISSUES / ALLERGIES:

Child 1 - Allergy_____ Health Issue: _____

Child 2 - Allergy_____ Health Issue: _____

Child 3 - Allergy_____ Health Issue: _____

MEDIA RELEASE:

I grant permission to use my child's image and/or name in print, electronic, or digital format for school publication, publicity, and website. (Select one) ☐ Yes ☐ No

2018-2019 ANGEL FUND (Annual Fund):

St. Aloysius School is grateful for all those who choose to support our mission in making our school a charitable priority. Your generosity in the form of an Angel Fund gift supports our efforts to provide the very best in Catholic education and to help St. Aloysius School thrive for many more years to come.

If you would like to make your 2018-2019 Angel Fund donation, please check below and enclose a check made payable to St. Aloysius School (please write "Angel Fund" in the memo).

☐ Enclosed is my check for my 2018-2019 Angel Fund donation in the amount of $_____

SIGNATURE:

I hereby certify that all the above information is accurate. I agree to pay all tuition and to abide by the policies and procedures of St. Aloysius School as stated in the school handbook.

Signature of person(s) making application:

_____ **Date:**_____

_____ **Date:**_____