200 South Walnut Street
Batesville, IN 47006

ST. LOUIS CATHOLIC PRESCHOOL

Phone: (812) 932-1731
www.st.louisschool.org

STUDENT INFORMATION	**DATE:**
STUDENTS FULL NAME:	**2-DAY** or **3-DAY (Circle one)**
NAME STUDENT GOES BY:	GENDER:
DATE OF BIRTH:	AGE:
STUDENTS ADDRESS:	
CITY, ST ZIP:	
STUDENTS MAILING ADDRESS (If Different)	
HOME PHONE:	
PRIMARY LANGUAGE SPOKE AT HOME:	
RELIGIOUS AFFILIATION:	
COUNTY OF RESIDENCE:	
SCHOOL DISTRICT OF RESIDENCE:	
ETHNICITY: *Please Circle:* American Indian, Black (Not of Hispanic Origin), Asian or Pacific Islander, Hispanic, White (Not of Hispanic organ), Multiracial	
PARENT INFORMATION	
MOTHER NAME:	
HOME PHONE:	
MOTHER DAY PHONE:	
MOTHER CELL:	
MOTHER EMAIL ADDRESS:	
MOTHER EMPLOYER:	
FATHER NAME:	
HOME PHONE:	
FATHER DAY PHONE:	
FATHER CELL:	
FATHER EMAIL ADDRESS:	
FATHER EMPLOYER:	
EMERGENCY INFORMATION	
CONTACT 1	
HOME PHONE: CELL:	WORK:
RELATIONSHIP:	
CONTACT 2	
HOME PHONE: CELL:	WORK:
RELATIONSHIP:	
CONTACT 3	
HOME PHONE: CELL:	WORK:
RELATIONSHIP:	
DOCTOR NAME: DOCTOR PHONE:	
DENTIST NAME: DENTIST PHONE:	
SIBLINGS ATTENDING ST. LOUIS CATHOLIC SCHOOL:	

ADDITIONAL HELPFUL INFORMATION:
Please check any health conditions student has:
☐ ADD/ADHD
☐ Allergies, *if yes, to what?*
List Allergy Symptoms?
☐ Asthma with Inhaler*
☐ Diabetes*
☐ Dietary Restrictions
☐ Epilepsy/Seizure Disorder
☐ Hearing Aids
☐ Hearing Loss ☐ *Right* ☐ *Left*
☐ Heart Condition, *please specify*
☐ Migraine Headaches *Doctor Diagnosed*
Orthopedic limitations due to muscle, bone or spine? *Please specify.*
Life threatening allergies to: ☐ Benadryl* ☐ Has an Epi-Pen*
☐ Vision Loss ☐ *Wears Glasses*
***Requires parent and physician permission form and care plans to be completed.**

All medications need to be accompanied by parent and/or physician permission forms that are available in the school office and on our website. No student is to carry any medication on them without permission from the Principal. The information on this form will be shared with other school personnel as necessary for the well being of your child.

In the event of extreme illness or accident, my child may be taken to our family doctor, if available, (or any doctor decided by designated school officials) and give whatever emergency treatment is necessary as determined by the examining physician. This will be done only if none of the persons on this record can be notified.

_____ _____

PARENT SIGNATURE PARENT SIGNATURE

_____ _____

DATE DATE