

For Office Use:

Fee:

# Application For Enrollment



## Application Checklist

You MUST provide all documents listed below in order for the application to be complete. If you should have any questions, please contact a member of our administrative team.

1. Non-Refundable Registration Fee per application
2. Applicant's Birth Certificate
3. Applicant's Baptismal Certificate
4. Applicant's Immunization Records
5. Enrollment Contract
6. Applicant's Standardized Test Scores & Current/Previous Report Cards (1st-8th grade applicant only)

## Student Information

Student's Name \_\_\_\_\_  
 LAST FIRST M.I.

Birthday \_\_\_\_\_ Age \_\_\_\_\_ Place of Birth \_\_\_\_\_

Student's Home Address \_\_\_\_\_  
 STREET CITY STATE

Home/Primary Phone # \_\_\_\_\_ Gender  M  F Religion of Applicant \_\_\_\_\_

Present Grade \_\_\_\_\_ Grade Applying For \_\_\_\_\_ \*Final placement will be determined by the school.

Please check the appropriate box(es) on your child's ethnic background:

- African American
- American Indian
- Asian
- Caucasian
- Hispanic/Latino
- Pacific Islander
- Multi-Racial
- Other

## Previous School Information (New Students Only)

School Name \_\_\_\_\_

## Parent Information

Parent Name \_\_\_\_\_

Primary Phone #s (h) \_\_\_\_\_ (c) \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary Email Address \_\_\_\_\_

Religion \_\_\_\_\_ Parish \_\_\_\_\_  
 (To receive the parishioner tuition discount, your stewardship form must be on file in the parish and school offices.)

SJA Alum?  Y  N Year \_\_\_\_\_

With whom does the applicant live?

Please check the appropriate box:

- Mother & Father
- Mother & Stepfather
- Mother Only
- Father & Stepmother
- Father only
- Joint Custody
- Legal Guardian(s)

Parent Name \_\_\_\_\_

Primary Phone #s (h) \_\_\_\_\_ (c) \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary Email Address \_\_\_\_\_

Religion \_\_\_\_\_ Parish \_\_\_\_\_  
 (To receive the parishioner tuition discount, your stewardship form must be on file in the parish and school offices.)

SJA Alum?  Y  N Year \_\_\_\_\_

Who is/are the legal guardian(s) of this child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*If either parent has a different address/phone number than the student, please provide below.

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

Address \_\_\_\_\_  
 Street City State Zip

**St. Joan of Arc  
 Catholic School**  
 500 E. 42nd Street  
 Indianapolis, IN 46205  
 317-283-1518 phone  
 317-931-3380 fax  
 Please direct any questions  
 to our administrative team

Tour Guide Name: \_\_\_\_\_

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# Education & Health History Form



You will be asked to provide this information one time only.

Student Applicant's Name \_\_\_\_\_

## Educational Background Information

Does your child have an IEP? (Individual Education Plan?)  Y  N

Do you have concerns about your child's learning abilities and style?

Please describe anything you think we should know about your child's past educational experiences.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Please tell us more about your child.

We must know your child as a total person in order to provide the best educational experience for your child and to meet our educational mission. This information is confidential and is needed in order to better serve your child. Feel free to attach any reports or documents from your child's previous experience.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health History

Student Applicant's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Did your child have any problems immediately at or after birth or during early his/her childhood development? Please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child wear glasses?  Y  N

Does your child have a hearing problem or have frequent ear infections?  Y  N

Does your child have limitations in activities?  Y  N

Please explain \_\_\_\_\_

Does your child have specific health problems such as:

- Heart \_\_\_\_\_  Eye Problems \_\_\_\_\_
- Convulsions \_\_\_\_\_  Ear and/or Throat Problems \_\_\_\_\_
- Diabetes \_\_\_\_\_  Asthma \_\_\_\_\_
- Food Allergies \_\_\_\_\_  Medicine Allergies \_\_\_\_\_
- Other \_\_\_\_\_

Does your child take any medication regularly?  Y  N

Please list all medications \_\_\_\_\_

Has your child had any surgeries?  Y  N

Please describe the nature of the surgery and date

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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# Additional Information



**Important:  
Please  
Sign:**

**Three signatures are required to complete this form. Please make sure you have read this page carefully.**

## Student's Sacramental Information

Baptism Year \_\_\_\_\_ Church \_\_\_\_\_  
Reconciliation Year \_\_\_\_\_ Church \_\_\_\_\_  
First Eucharist Year \_\_\_\_\_ Church \_\_\_\_\_

### SJA Student Handbook

I do hereby grant St. Joan of Arc School and Parish the right to publish my child's contact information (address, phone number, email address) in the student handbook.

**Sign Here:**

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

### Photograph/Image Release

I do hereby grant St. Joan of Arc School and Parish and its employees and contractors the right to photograph my dependent (during school hours and school functions) and use the photo(s) and/or other digital reproduction(s) of him/her physical likeness for publication purposes.

**Sign Here:**

Signature of parent/guardian \_\_\_\_\_

Date \_\_\_\_\_

## Dismissal Procedure Information

Will your child be attending our before-school program?  Y  N  
Will your child be attending our NYO after-school program?  Y  N  
Will your child be allowed to walk home from school?  Y  N

### Pick-Ups

Please name THREE people (and contact information for each) for pick-up.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### In case of Illness or Emergency (Make contact in the following order)

First Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Second Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Third Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Doctor \_\_\_\_\_ Phone# \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Does your child have any food or drug allergies?  Y  N \_\_\_\_\_

Does your child take any medication regularly?  Y  N \_\_\_\_\_

Does your child have any changes in their health history?  Y  N \_\_\_\_\_

Parent/Guardian Signature (required) \_\_\_\_\_

Date \_\_\_\_\_

Thank you for your cooperation in helping to make your child's educational experience a success!

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