

1. Are you a registered member of St. James Parish? Yes (*go to question 2*) No
- a. If no, and you are Catholic, please indicate the name and location of the parish in which you are registered.

b. If no, and you are non-Catholic, please indicate your religious affiliation and place of worship.

2. If you or another family member is a St. James alumnus, indicate name(s) and year(s) of graduation. _____
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STUDENT BACKGROUND

3. What school does your child currently attend? (Address, including city and zip code must be include)

School name _____ Address _____

City, State, Zip _____

All new students are accepted on a probationary basis. I give permission for my child's current teacher to be contacted.

Teacher's name _____

School _____ School phone number _____

4. If you did not list a public school in question 3, please indicate the public school and district where you child would be attending.

School _____ District _____

5. Has your child previously been in a

Speech program	yes <input type="checkbox"/> no <input type="checkbox"/>	Learning disability program	yes <input type="checkbox"/> no <input type="checkbox"/>
Gifted program	yes <input type="checkbox"/> no <input type="checkbox"/>	Physically challenged program	yes <input type="checkbox"/> no <input type="checkbox"/>

6. How did you hear about St. James Academy? _____

8. Medical History (*Check yes or no.*)

Allergies	yes <input type="checkbox"/> no <input type="checkbox"/>	Eyeglasses	yes <input type="checkbox"/> no <input type="checkbox"/>
(Specify) _____		Emotional illness	yes <input type="checkbox"/> no <input type="checkbox"/>
Attention deficit disorder (ADD)	yes <input type="checkbox"/> no <input type="checkbox"/>	Hearing difficulty	yes <input type="checkbox"/> no <input type="checkbox"/>
Bone and joint illness	yes <input type="checkbox"/> no <input type="checkbox"/>	Speech difficulty	yes <input type="checkbox"/> no <input type="checkbox"/>
Convulsions or fainting	yes <input type="checkbox"/> no <input type="checkbox"/>	Visual difficulty	yes <input type="checkbox"/> no <input type="checkbox"/>
Diabetes	yes <input type="checkbox"/> no <input type="checkbox"/>	Other (specify) _____	

Child's Physician _____ Phone _____

Child's Hospital or HMO _____ Phone _____

9. Other children in family currently attending St. James:

Name/grade _____	Name/grade _____
Name/grade _____	Name/grade _____