

Christ the King Catholic School  
52473 State Route 933  
South Bend, IN 46637  
Phone :( 574)272-3922 Fax :( 574)273-6707

Dear Parent or Guardian:

Thank you for your interest in Christ the King Catholic School. Enclosed you will find the forms necessary to begin the application process for your child.

Please remember that submitting the application does not mean your child has been admitted to Christ the King Catholic School. Besides the required forms, an interview with an administrator may be required.

Below is a checklist of items that are needed to begin the application process. All information (excluding the physician and dentist forms) is to be submitted at the same time. Those two forms are due no later than May 1<sup>st</sup>. If you have any questions, please contact the school office.

- \_\_\_\_\_ Completed Application Form (3 pages)
- \_\_\_\_\_ Authorization to Release Information (Gr. 1-8 if coming from a previous school)
- \_\_\_\_\_ Survey of Special Needs
- \_\_\_\_\_ Ethnicity Form
- \_\_\_\_\_ Copy of Birth Certificate (Legal County or State Document Not Hospital Certificate)
- \_\_\_\_\_ Copy of Baptismal Certificate, First Communion, and Confirmation Certificate (if Catholic)
- \_\_\_\_\_ Copy of Social Security Card
- \_\_\_\_\_ Student Health Questionnaire (Parents fill out this form)
- \_\_\_\_\_ Physician Certificate of Examination/Immunization Form (new Kdg. & 1<sup>st</sup> gr. only) (Due no later than May 1<sup>st</sup>)
- \_\_\_\_\_ Dental Exam Form (new Kdg. & 1<sup>st</sup> gr. only) (Due no later than May 1<sup>st</sup>)
- \_\_\_\_\_ Copy of Standardized Test Results or Academic Record
- \_\_\_\_\_ Copy of Custody Agreement (if applicable)
- \_\_\_\_\_ Letter from previous pastor stating active participation at your previous parish. (if transferring from another Catholic Church to Christ the King)

Please return all required items to the School Office. The School will notify you upon acceptance. Space is limited. Applications may be considered in the order they are received.

## Christ the King School Application Form

Date of Application: \_\_\_\_\_ 52473 State Road 933 North Kindergarten Preference  
Grade Applying for: \_\_\_\_\_ South Bend, IN 46637 Circle One  
Academic Year of: \_\_\_\_\_ phone 574-272-3922 **Full Day** **Half Day**  
In what Parish are you enrolled? \_\_\_\_\_ fax 574-273-6707 AM

Student's Legal Name \_\_\_\_\_  
*Last First Middle Sex Date of Birth Place: City State*

Residential Address \_\_\_\_\_  
*Street City State Zip Phone*

Previous School \_\_\_\_\_  
*Name Address (if not local) City State Zip*

Student lives with: Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Stepmother \_\_\_\_\_ Stepfather \_\_\_\_\_  
Legal Guardian(s) \_\_\_\_\_ Relatives \_\_\_\_\_ Grandparents \_\_\_\_\_ Other \_\_\_\_\_

Student's Religion \_\_\_\_\_

Baptism: Date \_\_\_\_\_ Church \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Communion: Date \_\_\_\_\_ Church \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Confirmation: Date \_\_\_\_\_ Church \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### LIST ALL CHILDREN IN FAMILY (PLACE \* IN FRONT OF THIS CHILD'S NAME)

Oldest 1. Name \_\_\_\_\_ Age \_\_\_\_\_ 5. Name \_\_\_\_\_ Age \_\_\_\_\_  
2. Name \_\_\_\_\_ Age \_\_\_\_\_ 6. Name \_\_\_\_\_ Age \_\_\_\_\_  
3. Name \_\_\_\_\_ Age \_\_\_\_\_ 7. Name \_\_\_\_\_ Age \_\_\_\_\_  
4. Name \_\_\_\_\_ Age \_\_\_\_\_ 8. Name \_\_\_\_\_ Age \_\_\_\_\_

School District of Residence: \_\_\_\_\_

Public School your child would attend: \_\_\_\_\_

Email address for correspondence from CKS: \_\_\_\_\_

**Application Page 2  
Parent Information**

Father's Name: First \_\_\_\_\_ Last \_\_\_\_\_ Living \_\_\_\_ Deceased \_\_\_\_

Father's Religion \_\_\_\_\_

Father's Work Place: \_\_\_\_\_

Father's Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Father's Cell Phone: (\_\_\_\_) \_\_\_\_\_

Father's Email Address \_\_\_\_\_

Mother's Name: First \_\_\_\_\_ Last \_\_\_\_\_ Living \_\_\_\_ Deceased \_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

Mother's Religion \_\_\_\_\_

Mother's Work Place: \_\_\_\_\_

Mother's Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Mother's Cell Phone: (\_\_\_\_) \_\_\_\_\_

Parents' Marital Status: \_\_\_\_ Married \_\_\_\_ Divorced\* \_\_\_\_ Separated\* \_\_\_\_ Single \_\_\_\_ Remarried\*

**\*COPY OF CUSTODY/GUARDIANSHIP PAPERS REQUIRED**

**Emergency Contacts and Medical Information**

**Emergency Contact 1** (someone other than a parent) \_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency Contact 1** Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

**Emergency Contact 2** (someone other than a parent) \_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency Contact 2** Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

**Emergency Contact 3** (someone other than a parent)  
\_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency Contact 3** Home Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

If emergency treatment is required, school authorities may follow city or area EMS regulations in sending my child to the hospital.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_ **Parent or Guardian**

**Application Page 3**

Allergies: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Child's primary language \_\_\_\_\_ Primary language spoken in the home \_\_\_\_\_

Primary written language of parent(s)/guardian \_\_\_\_\_

**Guardianship Information** (other than parent)

Name of Guardian with whom the child is living \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Enrollment in Christ the King School is subject to approval of the Diocese and the Christ the King School administration. Enrollment approval, if granted, may be rescinded by the Diocese or School at any time consistent with Diocesan policy or the School handbook.

**Have you applied to other schools?**    \_\_\_\_\_ **Yes**    \_\_\_\_\_ **No**

**If so, which ones?** \_\_\_\_\_

**Will you need after school care?**    **Yes**    **No (Circle One)**

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_

Admission is not determined until an admissions interview is conducted (if necessary) and confirmation is received from your previous Catholic school, if applicable, that financial obligations are current. (P5270)

Christ the King Catholic School  
52473 State Route 933  
South Bend, IN 46637  
Phone :( 574)272-3922 Fax :( 574)273-6707

Date: \_\_\_\_\_

**REQUEST FOR RECORDS**

To Whom It May Concern at:

**School Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Please be advised that we have recently enrolled:

**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Grade** \_\_\_\_\_

Please send a transcript of grades, results of any achievement and intelligence tests, attendance and health records, and any other pertinent data available.

Please release to:

Christ the King School  
Attn: Records  
52473 State Road 933  
South Bend, IN 46637  
Phone: 574-272-3922  
Fax: 574-273-6707

Thank you,  
Sincerely,  
Laura Hager  
Associate Principal

**CHRIST THE KING CATHOLIC SCHOOL  
SURVEY OF SPECIAL NEEDS**

We at Christ the King Catholic School are in a partnership with parent(s) or guardian(s), to provide the best education for their Child/our student. Any information that assists us in this task ultimately benefits your son or daughter. The following information is requested to ensure that each student's individual learning needs are met to the best of our ability. Failure to provide this information may inhibit the staff's ability to meet the individual needs of your child, and consequently, the school reserves the right to forego acceptance or continuation of the child in our School if such information is not provided.

1. Has your child been tested for any special concerns – academic, behavioral or other? If yes, please explain:

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2. Has your child ever been on medication for educational/behavioral purposes? If yes, please explain:

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3. Has your child ever been referred for special educational services? If so, what type, by whom and with what result?

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4. Has your child had special educational services provided? If yes, please explain:

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5. Has your child ever been under the care of a professional counselor, psychologist, or psychologist, or psychiatrist? If so, please explain:

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**These next two questions must be answered:**

6. Are you willing to share all previous and future special education information/tests with the Administration of Christ the King Catholic School? \_\_\_Yes \_\_\_No
7. Are you willing to sign a release to allow the Administration to speak with the person(s) who conducted any of these services or tests or prepared any information? \_\_\_Yes \_\_\_No

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**Parent/Guardian Signature**

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**Date**

# Ethnicity Form

The State is requiring ethnicity information for your child / children. Using the guideline below, please complete this form. This information is ONLY for statistical purposes. Christ the King School welcomes students of all ethnic backgrounds.

**Asian:** identifies as having origins in Far East, Southeast Asia or Indian Sub-Continent (Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippines, Thailand, Vietnam etc.)

**American Indian / Native Alaskan:** identifies as one of the two classifications of Native Americans

**Black / African American:** identifies as black whether from US, Africa, or other parts of the world

**Hispanic:** identifies as of Hispanic origin

**Native Hawaiian / Pacific Islander:** includes native Hawaiians living anywhere in the US also includes other Pacific Islands: Guam, Samoa, Fiji, Micronesia, Polynesia

**White:** Caucasian from any part of the world, including Middle East and does not identify as one of the other groups

**Multi-Racial:** person belonging to more than one racial group

Students Name: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Students Name: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

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Students Name: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Students Name: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Health Questionnaire  
 (Parent/Guardian needs to complete)  
 Please Print!

**Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**School:** \_\_\_\_\_ **Entering Grade:** \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Student Lives With: \_\_\_\_\_

Disease/Condition	Yes (List month/year)	No	Disease/Condition	Yes (List month/year)	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Scarlet Fever		
Measles			Other		

Has your child had an infectious/communicable disease other than those listed above? Please explain giving relevant dates: \_\_\_\_\_

**Please list any of the following with the month/year:**

Operations: \_\_\_\_\_

Illnesses (Eye, ear, heart, stomach, kidney): \_\_\_\_\_

Severe Injuries (Head Injury, Fractures, etc.): \_\_\_\_\_

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment? \_\_\_\_\_

Please list any condition that should be considered in planning your child's school day:  
 \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Immunization Requirements

Kindergarten and First Grade: 5DTaP, 4 Polio, 2 MMR, 3 Hepatitis B, 1 Varicella or a history of the Chicken Pox

Second through Fifth Grade: 5 DTaP, 4 Polio, 2 MMR, and 3 Hepatitis B

Sixth through Eighth: 4 DTaP, 4 Polio, and 2 MMR

**Please note the NEW immunization requirement for Kindergarten and First Grade. Each child must now have had the Chicken Pox or the vaccine (Varicella).**

The State of Indiana recognizes only 2 reasons for non-immunization of children. One is medical. If your child has a medical reason for not being immunized there is a form that MUST be filled out annually. The only Health Care Providers that are able to sign this form are a MD or DO.

The second reason is religious. If this is the reason, a form must be signed annually by the parent.

Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies \_\_\_\_\_

**Current Medications:** (List name, dosage, and time)

1. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_
2. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_
3. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_

Eyes: \_\_\_\_\_

Ears: \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: \_\_\_\_\_

Chest: \_\_\_\_\_

Heart: \_\_\_\_\_

Hernia: \_\_\_\_\_

Extremities: \_\_\_\_\_

Posture/Scoliosis: \_\_\_\_\_

**Lead Level** (if indicated): \_\_\_\_\_

**Sickle Cell** (If indicated): \_\_\_\_\_

**P.P.D.: (Recommended)**

Date Given: \_\_\_\_\_

Date Read: \_\_\_\_\_

Results: \_\_\_\_\_

- Physically fit to participate in all physical education programs? Yes No  
If "No" please explain: \_\_\_\_\_
- Please list any condition that should be considered in planning this child's school day: \_\_\_\_\_

**Immunization Record: (Month/Day/Year)**

D.T.P.	Hepatitis B:	H.I.B.
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____		4. _____
5. _____		

**MMR:**

IPV (please indicate if OPV)		Prevnar:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____		3. _____
4. _____		4. _____

Varicella:  
1. \_\_\_\_\_

Physician Completing this form: \_\_\_\_\_

**Please Print/Stamp**

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_

# Certificate of Dental Examination

**Please Print**

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

Last

First

Middle Initial

Parent/Guardian Name \_\_\_\_\_

School \_\_\_\_\_

**This form is to be completed by your dentist.**

## Dental Examination

Code: No Defect = 0

Defect = Note Condition

### 1. Teeth

1. Cavities \_\_\_\_\_
2. Malocclusion \_\_\_\_\_
3. Soft Tissue \_\_\_\_\_
4. Oral Hygiene \_\_\_\_\_

### 2. Present Status

- Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
- If yes, please explain \_\_\_\_\_

### 3. Recommendations

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Print/Stamp Dentist's Name

Signature

\_\_\_\_\_  
Date