



BISHOP BAUMGARTNER MEMORIAL CATHOLIC SCHOOL

281 Calle Angel Flores, Sinajana, Guam 96910
671-472-6670/671-477-2677/671-477-1026/ 671-477-4028(fax)

DO NOT WRITE HERE FOR ASSESSMENT PURPOSES ONLY

NEW STUDENT REGISTRATION FORM

Lost Registration Form \$5.00 fee

STUDENT # _____
 Birth Certificate
 Baptismal Certificate
 Transferee Report Card
 Medical/Physical Form
 Immunization Record
 RenWeb
Signed by: _____

STUDENT INFORMATION

SCHOOL YEAR 2018-2019 GRADE ENTERING (please check one) K 1 2 3 4 5 6 7 8

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

NICK NAME _____ GENDER M F BIRTHDATE _____ AGE _____ PLACE OF BIRTH _____

SOCIAL SECURITY # _____ HOME PHONE _____ CELLPHONE _____

HOME ADDRESS _____

ETHNICITY _____ (if blank choose from below) LEGAL STATUS _____ (if blank choose from below)

MULTI-RACIAL (if multi-racial please choose the ethnicities below that comprise the racial mix.)

- | | | | |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> Chamorro | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Palauan | <input type="checkbox"/> U.S. Citizen |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> African-American | <input type="checkbox"/> Other(s) (please specify) _____ | <input type="checkbox"/> Dependent of Non-Immigrant Worker/H4 |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Hispanic | _____ | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Chuukese | _____ | <input type="checkbox"/> Resident Alien |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Yapese | _____ | Alien Registration # _____ |

CHILD LIVES WITH _____ (if blank choose from below) TRANSPORTATION TO SCHOOL _____

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Grandparents | <input type="checkbox"/> Relatives (please specify) _____ | <input type="checkbox"/> Private Car |
| <input type="checkbox"/> Father | <input type="checkbox"/> Grandfather | _____ | <input type="checkbox"/> Bus |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Grandmother | _____ | <input type="checkbox"/> Car Pool |
| <input type="checkbox"/> Takes turns between Father and Mother | <input type="checkbox"/> Uncle and Aunt | <input type="checkbox"/> Other (please specify) _____ | |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Other (please specify): _____ | _____ | |

• Does your child have specific learning difficulties? Yes ___ No ___ Please provide details: _____

• Has your child been diagnosed with Attention Deficit Disorder (ADD) / Attention Deficit Hyper-Activity Disorder (ADHD)? Yes ___ No ___ Please provide details: _____

• Does your child have an Individual Education Plan (IEP)/ or Individual Services Plan (ISP)? Yes ___ No ___

RELIGION CATHOLIC CHRISTIAN, Please specify denomination _____ Other (please specify) _____

BAPTISM

FIRST HOLY COMMUNION

Date ___/___/___ Date ___/___/___
Church _____ Church _____
Place _____ Place _____
Parish: _____

Brother(s) and/or sister(s) presently enrolled at BBMCS



PARENT'S INFORMATION - MOTHER

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

HOME ADDRESS _____

MAILING ADDRESS _____
(if different from above)

HOME PHONE _____ MOBILE PHONE _____ EMAIL _____

EMPLOYED SELF-EMPLOYED COMPANY NAME _____

WORK ADDRESS _____

OCCUPATION _____ WORK PHONE _____ SOCIAL SECURITY # _____

NATIONALITY _____ ETHNICITY _____ ALIEN REGISTRATION #(if applicable) _____

MARITAL STATUS : SINGLE MARRIED SEPARATED DIVORCED WIDOWED IF DIVORCED, REMARRIED? YES NO

RELIGION _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

BISHOP BAUMGARTNER / ST. JUDE GRADUATE? YES NO IF YES, YEAR GRADUATED _____

PARENT'S INFORMATION - FATHER

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

HOME ADDRESS _____

MAILING ADDRESS _____
(if different from above)

HOME PHONE _____ MOBILE PHONE _____ EMAIL _____

EMPLOYED SELF-EMPLOYED COMPANY NAME _____

WORK ADDRESS _____

OCCUPATION _____ WORK PHONE _____ SOCIAL SECURITY # _____

NATIONALITY _____ ETHNICITY _____ ALIEN REGISTRATION #(if applicable) _____

MARITAL STATUS : SINGLE MARRIED SEPARATED DIVORCED WIDOWED IF DIVORCED, REMARRIED? YES NO

RELIGION _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

BISHOP BAUMGARTNER / ST. JUDE GRADUATE? YES NO IF YES, YEAR GRADUATED _____



GUARDIAN'S INFORMATION (if child is living with guardian)

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

RELATION TO CHILD STEPMOTHER STEPFATHER AUNT UNCLE SISTER BROTHER
 GRANDMOTHER GRANDFATHER Other, please specify _____

MAILING ADDRESS _____

HOME PHONE _____ MOBILE PHONE _____ EMAIL _____

EMPLOYED SELF-EMPLOYED COMPANY NAME _____

WORK ADDRESS _____

OCCUPATION _____ WORK PHONE _____ SOCIAL SECURITY # _____

MARITAL STATUS : SINGLE MARRIED SEPARATED DIVORCED WIDOWED IF DIVORCED, REMARRIED? YES NO

RELIGION _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

BISHOP BAUMGARTNER / ST. JUDE GRADUATE? YES NO IF YES, YEAR GRADUATED _____

EMERGENCY CONTACT

In case of emergency, the school immediately contacts the parents. If parents are not available, please provide the information below for the name of the person(s) to contact should an emergency arise.

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

RELATION TO CHILD STEPMOTHER STEPFATHER AUNT UNCLE SISTER BROTHER
 GRANDMOTHER GRANDFATHER Other, please specify _____

HOME PHONE _____ WORK PHONE _____ MOBILE PHONE _____

EMAIL ADDRESS _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

RELATION TO CHILD STEPMOTHER STEPFATHER AUNT UNCLE SISTER BROTHER
 GRANDMOTHER GRANDFATHER Other, please specify _____

HOME PHONE _____ WORK PHONE _____ MOBILE PHONE _____

EMAIL ADDRESS _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

Student's Name: _____ *Homeroom:* _____

PARENTAL INVOLVEMENT

Bishop Baumgartner Memorial Catholic School encourages our families to participate in the development and education of our children. Please identify any particular committees, services or other areas where you would like to contribute your time or resources:

- _____ Classroom/Homeroom helper
- _____ Lunch Break Activities Instructor
- _____ Extracurricular Activities/Coaching
- _____ Athletics (specify): _____
- _____ Annual Fun Run
- _____ Annual Golf Tournament
- _____ Other: _____

Signature of Parents/Guardian : _____



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SCHOOL YEAR 2018-2019 GRADE (please check one) K 1 2 3 4 5 6 7 8

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

FINANCIAL OBLIGATION

1. Please indicate the person responsible for the Financial obligation of the child.

- PARENTS
- FATHER
- MOTHER
- if other, please complete the following:

LAST NAME _____ FIRST NAME _____ MIDDLE NAME(S) _____

RELATION TO CHILD STEPMOTHER STEPFATHER AUNT UNCLE SISTER BROTHER
 GRANDMOTHER GRANDFATHER Other, please specify _____

HOME PHONE _____ WORK PHONE _____
MOBILE PHONE _____ EMAIL ADDRESS _____
MAILING ADDRESS _____

2. Choose a payment option below.

- OPTION A : Annual Payment (due on or before August 31, 2018)
- OPTION B : Ten-Month Payment Plan (due every 1st of the month)
(monthly payment starting on August 1, 2018 to May 1, 2019)

AGREEMENT TO ASSUME FINANCIAL RESPONSIBILITIES and ABIDE BY RULES, REGULATIONS and POLICIES OF BISHOP BAUMGARTNER MEMORIAL CATHOLIC SCHOOL.

In consideration of the enrollment and education of the students identified herein, the undersigned Parents or Guardians agree to pay any and all costs, registration, tuition, fees and assessments incurred while student is enrolled at BISHOP BAUMGARTNER MEMORIAL CATHOLIC SCHOOL (BBMCS). Such fees and costs include, but are not limited to, registration fees, tuition fees, extended care fees, book fees, instructional fees, assessments, cafeteria fees and such other fees and costs as may be imposed by BBMCS. I understand that registration fees are non-refundable, and monthly tuition fees and extended care fees are due for any period of any month that the student remains enrolled in BBMCS. We agree to pay the tuition fees as follows:

- () **Annual Payment: DUE ON OR BEFORE AUGUST 31, 2018 (5% discount for payment in full)**
- () **10 Month Payment Plan: FIRST PAYMENT DUE AUGUST 1, 2018 with the remainder of payment due on the FIRST OF EACH MONTH, FINAL PAYMENT DUE PRIOR TO FINAL EXAMS. Payment made after the 10th of each month will result in a 10% late fee penalty.**
- () **Return Check Fee \$50.00**

It is understood and agreed as follows: Should payments be made with checks which are returned unpaid for any reason, BBMCS will assess the undersigned all costs of the returned check, and may require as a condition of continued enrollment, that all future payments be made by means other than personal check. The obligation of the undersigned to pay the tuition for the period of enrollment is unconditional and no portion of such tuition paid or outstanding will be refunded or cancelled regardless of the subsequent absence, withdrawal or dismissal from BBMCS, subject to verification by BBMCS. The Parents or Guardians shall make all payments when they become due, and if not made within thirty (30) days, the Parents or Guardians shall be in default of this agreement and BBMCS shall have the right to terminate the student's enrollment and disallow the student to attend further classes or activities at the school, and deny access to any and all information and records concerning the students, including denial of the opportunity to sit for examinations or graduate. Further, BBMCS shall be entitled to collect and receive all remaining balances due under this Agreement regardless of the student's withdrawal or dismissal, together with all costs and attorney's fees incurred in the collection of sums due and owing to BBMCS. In the event any legal action or proceeding or any other action is initiated to enforce or collect under the provisions of this Agreement, BBMCS shall be entitled to reasonable attorney's fees and costs of collection.

Medical Authorization and Consent: In case of accident or emergency, the undersigned authorizes a staff member to take the student to the primary physician identified in the student's Medical History Form, or to the nearest hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the student, at the undersigned's expense. BBMCS agrees to make immediate attempts to notify the undersigned of any emergency. The undersigned hereby gives consent to BBMCS to provide emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S.) for the student. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of the student.

Consent Generally: The undersigned authorizes BBMCS to provide meals, snacks and beverages to the student, and agrees to give written notice to BBMCS of any allergies the student may have to food or drinks. The undersigned authorizes the student to use all indoor/outdoor equipment within BBMCS, under supervision of BBMCS, and grants permission for the student to participate in any and all activities with BBMCS. Parent further consents and grants permission to BBMCS, or its authorized representative, to take pictures and/or video of the student for use by BBMCS.

It is understood and agreed that by signing this Agreement for the current academic year, the Parents or Guardians hereby warrant and confirm that they have reviewed the BBMCS Parent/Student Handbook, and agreed to abide by its terms and conditions. It is also understood and agreed that the undersigned Parents or Guardians will support the Administration of BBMCS; However, in the event the Parents or Guardians do not feel they can support the Administration of BBMCS, they will promptly withdraw their students, remaining liable for all costs, tuition and fees incurred. It is understood and agreed that by signing this Agreement for the current academic year and any subsequent year that the student remains enrolled in BBMCS, the Parents or Guardians hereby assume, warrant and guarantee payment of the tuition, fees and assessment, and agree and accept the rules and regulations of the school, and agree to ensure that the students comply with said rules and regulations.

PARENT/GUARDIAN SIGNATURE

DATE



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MEDICAL / ATHLETIC CLEARANCE FORM FOR SCHOOL ADMISSION

NOTE : Please submit on or before 1st day of school.

STUDENT NAME _____ DATE _____
 DATE OF BIRTH _____ ETHNICITY _____
 GRADE ENTERING _____ SCHOOL YEAR _____
 HOME ADDRESS _____
 HOME PHONE _____ E-MAIL _____ PHYSICIAN'S NAME _____
 FATHER'S NAME _____ PHONE # _____ PHYSICIAN'S PHONE NO. _____
 MOTHER'S NAME _____ PHONE # _____ HOSPITAL/CLINIC _____

PART 1: PHYSICAL EXAMINATION

HEIGHT _____ WEIGHT _____ T _____ P _____ R _____
 BLOOD PRESSURE _____ VISION: RT _____ LT _____ HEARING: RT _____ LT _____

CHECK EACH LINE	NORMAL	ABNORMAL	NOT Examined	Describe suspicious or abnormal findings
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin, Hair, Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes : External (pupils-cornea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears : External	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auditory acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tymanogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pure Tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose, Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharynx, Larynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth, Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck, Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

PART 2: IMMUNIZATION RECORD: PLEASE ATTACH A COPY OF UPDATED IMMUNIZATION RECORD.

Please check one: Perfectly Healthy Specific Problem(s) Noted Disability
 This child is physically fit to participate in physical education and/or athletic events and related activities. Yes No
 Name of Physician (PRINT) _____ Signature _____
 Clinic _____ Email address _____
 Activities : Basketball Volleyball Cross Country Rugby Soccer Baseball
 Non-Contact Sports No Activities

TB Skin Test : Date Administered _____ Date Read: _____ Results: _____

Parental / Guardian Consent

I hereby give permission for the physician to examine my child so that he/she may obtain medical clearance to participate in athletic activities. Therefore, neither the examining physician nor the school is to be held liable for any abnormalities not detected in this examination. Permission is also granted to my child (NAME) _____ to participate in the athletic activities approved by the Physician as initialed above for school year: _____

PARENT/GUARDIAN SIGNATURE _____ DATE : _____

MEDICAL INFORMATION:

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

LAST NAME : _____ FIRST NAME: _____ MIDDLE NAME: _____

MEDICAL HISTORY: please check "No" or "Yes: appropriately.

- ALLERGIES: FOOD, MEDICATION, ETC _____ YES _____ NO If, yes, what? _____
- HEART PROBLEMS OR HEART DISEASE _____ YES _____ NO
- CHEST PAINS _____ YES _____ NO
- ASTHMA _____ YES _____ NO
- SHORTNESS OF BREATH _____ YES _____ NO
- HEAD INJURIES _____ YES _____ NO If, yes, when? _____
- FRACTURES _____ YES _____ NO If, yes, when? _____
- WEAK JOINTS OR BACK PROBLEMS _____ YES _____ NO
- TAKING MEDICATION _____ YES _____ NO If, yes, what medication? _____
For what reason? _____
- SURGERY _____ YES _____ NO Type? _____
When? _____
- BLOOD DISORDER _____ YES _____ NO
- HERNIA _____ YES _____ NO
- RHEUMATIC FEVER _____ YES _____ NO
- DIABETES _____ YES _____ NO
- HEARING PROBLEMS _____ YES _____ NO
- VISION PROBLEMS: _____ YES _____ NO
 - GLASSES/CONTACTS NEEDED _____ YES _____ NO
- CONVULSIONS/SEIZURES OR _____ YES _____ NO
 - BREATHING SPELLS _____ YES _____ NO
- OTHER SERIOUS INJURY OR ILLNESS _____ YES _____ NO
(if yes, please explain below)

REMARKS:

To the best of my knowledge, the information on this page is accurate and complete.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____