



St. Francis de Sales Catholic School
500 Camden Avenue
Salisbury, Md. 21801
(410) 749-9907
www.stfrancisdesales.net

ST. FRANCIS DE SALES CATHOLIC SCHOOL _____ Date of Birth _____
 Pre-K applicants only (please check) Full day _____ ½ day _____
 City _____ State _____ Zip _____
 Area/Neighborhood _____ Home Phone _____ Religion _____
 Parish _____ Ethnicity _____ M F Soc. Sec. # _____
 Student resides with: _____ Guardian e-mail _____
 Parent's marital status: ___ married ___ separated ___ divorced ___ mother remarried ___ father remarried
 Mother's name _____ Employer _____
 Title/Position/Occupation _____ Work Phone _____ Cell Phone _____
 Father's name _____ Employer _____
 Title/Position/Occupation _____ Work Phone _____ Cell Phone _____
 Step parent name _____ Employer _____
 Title/Position/Occupation _____ Work Phone _____ Cell Phone _____
 School district student resides in: _____ County _____

Previous/Present school _____
 School Name Address

Reason for leaving _____

Please list your child's sacraments:

Sacraments	Date Received	Church	City and State
Baptism	_____	_____	_____
Reconciliation	_____	_____	_____
First Communion	_____	_____	_____
Confirmation	_____	_____	_____

Beginning with the oldest child please list children in family (including this child)

Birth Date	First Name	Religion	School Attending	Present Grade
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Emergency contact #1 (other than parents): Name _____ Relationship _____

Phone number _____ (circle one) cell home work

Emergency contact #2: Name _____ Relationship _____

Phone number _____ (circle one) cell home work

Emergency contact #3: Name _____ Relationship _____

Phone number _____ (circle one) cell home work

Doctor _____ Address _____ Phone _____

Dentist _____ Address _____ Phone _____

Ins. Co. _____ Policy holders name _____

Policy # _____ Policy holders SS# _____

Has your child had any of the following?

Allergies _____ Head Injury _____ Mononucleosis _____ Tonsillitis _____

Asthma _____ Hearing Condition _____ Mumps _____ Leukemia _____

Blood Disorder _____ Heart Condition _____ Pneumonia _____ Strep Throat _____

Broken bones _____ Hernia _____ Repeated Colds _____ Vision Defect _____

Chicken Pox (date) _____ Hyperactivity _____ Scarlet Fever _____ Ear Infection _____

Kidney Disorder _____ Seizure Disorder _____ Whooping Cough _____ Tumor _____

Tuberculosis Contact _____

Please circle if any of the following apply:

Instrumental delivery, Cesarean section, oxygen therapy, premature or incubator at birth

Is your child receiving medical treatment currently? Yes No If yes, why? _____

Does your child wear glasses, hearing aid, or other appliances? _____

Is your child restricted from physical activity? If yes, describe restriction _____

List allergies & reaction _____

Does your child require medication for these allergies? Yes No List any medications your child is currently taking _____

If any medication is to be dispensed at school, a medical dispensing form needs to be signed.

Please list injuries/diseases/operations and when they occurred _____

Other physical disabilities and/or medical conditions the school should be aware of _____

In case of an emergency illness, or accident to the child named above, the school is authorized to proceed as indicated above or as the school sees fit in an emergency.

I have included the following with this application: ___ Baptismal certificate ___ Birth certificate ___ Application fee

Parent/Guardian Signature _____ Date _____