



SANTA BARBARA CATHOLIC SCHOOL

Fully accredited by the Western Association of Schools and Colleges [WASC] and Western Catholic Educational Association [WCEA]
Member of National Catholic Educational Association [NCEA] Sisters of Mercy Education | Educating Mind, Heart, and Spirit
274 W Santa Barbara Ave Ste A, Dededo, Guam 96929-5378 TEL 632-5578 FAX 632-1414
EMAIL info@sbc.edu.gu WEBSITE <http://sbc.edu.gu>

STUDENT REGISTRATION FORM

NEW OLD RETURNING TEMPORARY

DO NOT WRITE HERE

Date Enrolled _____

- Birth Certificate
- Baptismal Certificate
- Transferee Report Card
- Medical / Physical Form
- Immunization Record
- Registration Form
- RenWeb

Signed by _____
School Secretary

STUDENT INFORMATION

SCHOOL YEAR _____ GRADE ENTERING (Please check one) PK 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 _____

HOME PHONE _____ MOBILE PHONE _____ E-MAIL ADDRESS _____

HOME ADDRESS _____

ETHNICITY _____ (if multi-racial choose from below) LEGAL STATUS _____

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

U.S. Citizen

(if blank choose from below)

Chamorro

Caucasian

Palauan

Dependent of Non-Immigrant Worker / H4

Filipino

African-American

Other(s) (Please specify) _____

Other (Please specify) _____

Chinese

Hispanic

Resident Alien

Japanese

Chuukese

Alien Registration # _____

Korean

Yapese

Vietnamese

Pohnpeian

CHILD LIVES WITH

TRANSPORTATION TO SCHOOL

Both Parents Both Grandparents Other Relatives (Please specify): _____

Private Car

Father(only) Mother(Only) _____

Bus

Grandfather(only) Grandmother(only) _____

Car Pool

Takes turns between Mother and Father Other (Please specify): _____

Step-Mother Step-Father _____

Guardian, please specify: _____

RELIGION Catholic Christian, please specify denomination _____ Other (Please specify) _____

BAPTISM DATE ____ / ____ / ____

FIRST HOLY COMMUNION DATE ____ / ____ / ____

CHURCH: _____

CHURCH: _____

PLACE: _____

PLACE: _____

Is your child a registered parishioner of Santa Barbara Church? Yes No

If No, please identify Parish: _____

Brothers and Sisters presently enrolled at Santa Barbara

PARENT'S INFORMATION - MOTHER

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

HOME ADDRESS _____

MAILING ADDRESS _____

(if different from above)

HOME PHONE _____ MOBILE PHONE _____ E-MAIL _____

EMPLOYED SELF-EMPLOYED COMPANY NAME _____

WORK ADDRESS _____

OCCUPATION _____ WORK PHONE _____

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 _____

SANTA BARBARA CATHOLIC SCHOOL 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 _____ E-MAIL _____

EMPLOYED SELF-EMPLOYED COMPANY NAME _____

WORK ADDRESS _____

OCCUPATION _____ WORK PHONE _____

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 _____

SANTA BARBARA CATHOLIC SCHOOL 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 _____ E-MAIL _____

EMPLOYED SELF-EMPLOYED COMPANY NAME _____

OCCUPATION _____ WORK PHONE _____

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 _____

SANTA BARBARA CATHOLIC SCHOOL 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 REGISTRATION FORM

NEW

OLD

RETURNING

TEMPORARY

FINANCIAL OBLIGATION

SCHOOL YEAR _____ GRADE (Please check one) PK K 1 2 3 4 5 6 7 8

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

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 _____

I hereby read and understand the rules & regulations as well as the financial obligations stated in student handbook.

Name
(Print & Sign)

Date

2. CHOOSE A PAYMENT OPTION BELOW.

PAYMENT OPTION

- OPTION A: Annual Payment (due upon registration)**
- OPTION B: Semi-Annual Payment**
(1st half due upon registration, 2nd half due January 5th of current school year)
- OPTION C: Ten-Month Payment Plan [due every 5th of the month]**
(monthly payment starting on August 1 to May 1 of current school year)

*See attached Credit/Debit Card Authentication if recurring monthly.

MODE OF PAYMENT

- Cash
- Check
- Credit Card*
- Debit Card*



STUDENT REGISTRATION FORM

NEW

OLD

RETURNING

TEMPORARY

ENROLLMENT AGREEMENT

We _____
(please print name)

I _____
Parent / Guardian of
(please print name)

and

Parents / Guardians of
(please print name)

Student Name

We do hereby pledge our support and promise to fulfill our responsibilities and financial obligations to the school; agree to conform with the rules and regulations that are stipulated in the Parent-Student Handbook; shall endeavor to participate actively in the spiritual and special functions as manifested in the School Calendar of Events and other special announcements.

We understand that by signing this agreement for the current academic year, we hereby assume, warrant and guarantee payment of tuition and other fees on time. If tuition payment is not made on or before the 5th of the month, we understand that a late charge of \$50.00 will be collected.

We also understand that we are responsible for keeping all receipts for tax purposes, and upon request of full statement for the calendar/tax year, a \$50.00 fee will be collected.

We also agree on the following:

The student is temporarily enrolled until his/her permanent record is obtained. His/Her academic performance and behavior will be observed during the first quarter. In the event that the child needs special academic assistance which the school cannot provide, parents will be notified. The administration and the parents will confer to make the most appropriate decision.

We promise to pick up our child right after school, between 2:50 and 3:30 p.m. If our child is a member of any school activity, e.g. Honor Choir, Interscholastic sports, MathCounts, Stu-Co, and NJHS, we promise to pick him/her up after the activity, the time of which will be made known to us by our child or by the teacher adviser. In the event the student is not picked up on due time, and something happens to him/her inside or outside the school grounds, we understand that the school is held free from any liability.

The school is hereby permitted to upload and post picture/videos in various electronic and printed mediums such as websites, social media, brochures, and newspapers

Signature of Parent / Guardian

Signature of Parent / Guardian

Date



MEDICAL CLEARANCE FORM FOR SCHOOL ADMISSION

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

NEW OLD RETURNING TEMPORARY

STUDENT NAME _____ DATE _____
 GRADE ENTERING (Please check one) PK K 1 2 3 4 5 6 7 8 SCHOOL YEAR _____
 DATE OF BIRTH _____ AGE _____ ETHNICITY _____
 HOME ADDRESS _____
 HOME PHONE _____ E-MAIL _____ PHYSICIAN'S NAME _____
 FATHER'S NAME _____ CELLPHONE _____ PHYSICIAN'S PHONE NO. _____
 MOTHER'S NAME _____ CELLPHONE _____ HOSPITAL/CLINIC _____
 BEST NUMBER TO CALL FOR EMERGENCY _____

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)				
optic fundus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears: External				
auditory acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tympanic membrane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tympanogram	<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"/>	_____
Genito-Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculo-Skeletal	<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 Handicapped

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 _____
 Health Insurance _____ Policy No _____

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 initiated for this 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.	NO	YES
ALLERGIES: FOOD, MEDICATION, ETC if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
HEART PROBLEMS OR HEART DISEAS if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAINS if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
HEAD INJURIES if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
FRACTURES if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
WEAK JOINTS OR BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
TAKING MEDICATION if YES, what kind? _____	<input type="checkbox"/>	<input type="checkbox"/>
SURGERY if YES, what type? _____	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
HERNIA	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
HEARING PROBLEMS if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
VISION PROBLEMS: GLASSES/CONTACTS NEEDED	<input type="checkbox"/>	<input type="checkbox"/>
CONVULSIONS/SEIZURES OR BREATHING SPELLS if YES, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
OTHER SERIOUS INJURY OR ILLNESS? IF YES, PLEASE EXPLAIN BELOW	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS:

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

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____