



# 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](mailto: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
- Filipino
- Chinese
- Japanese
- Korean
- Vietnamese
- Caucasian
- African-American
- Hispanic
- Chuukese
- Yapese
- Pohnpeian
- Palauan
- Other(s) (Please specify) \_\_\_\_\_

- Dependent of Non-Immigrant Worker / H4
- Other (Please specify) \_\_\_\_\_
- Resident Alien
- Alien Registration # \_\_\_\_\_

### CHILD LIVES WITH

- Both Parents
- Father(only)
- Grandfather(only)
- Takes turns between Mother and Father
- Step-Mother
- Guardian, please specify: \_\_\_\_\_
- Both Grandparents
- Mother(Only)
- Grandmother(only)
- Other (Please specify): \_\_\_\_\_
- Step-Father
- Other Relatives (Please specify): \_\_\_\_\_

### TRANSPORTATION TO SCHOOL

- Private Car
- Bus
- Car Pool

Authorized People for Pick up (Names and Contact #):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RELIGION  Catholic  Christian, please specify denomination \_\_\_\_\_  Other (Please specify) \_\_\_\_\_

BAPTISM DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
CHURCH: \_\_\_\_\_  
PLACE: \_\_\_\_\_

FIRST HOLY COMMUNION DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
CHURCH: \_\_\_\_\_  
PLACE: \_\_\_\_\_

Brothers and Sisters presently enrolled at Santa Barbara

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

If No, please identify Parish: \_\_\_\_\_

**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 \_\_\_\_\_

Committed Christians  
Creative, Critical Thinkers  
Effective Communicators  
Responsible Members of the Community



# Santa Barbara Catholic School

274-A W. Santa Barbara Ave., Dededo, GU 96929-5378 Tel: (671) 632-5578 Fax: (671) 632-1414

Fully accredited by Western Association of Schools and Colleges [WASC] and Western Catholic Educational Association [WCEA]



## 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 5<sup>th</sup> 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 5<sup>th</sup> 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 1<sup>st</sup> 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:

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

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_