

**BISHOP BROSSART HIGH SCHOOL**

**REGISTRATION DATA SHEET**

Name of Student \_\_\_\_\_  
First Middle Last

Male \_\_\_\_\_ Female \_\_\_\_\_ (Check One) Race \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ County of Residence \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Month/Day/Year

Place of Birth \_\_\_\_\_  
City State

Student Email Address \_\_\_\_\_

Parish Membership \_\_\_\_\_ Grade Entering \_\_\_\_\_

School Presently Enrolled In \_\_\_\_\_

Father's Name \_\_\_\_\_ Religion \_\_\_\_\_  
First Middle Last

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Remarried

BBHS Alumnus? \_\_\_ No \_\_\_ Yes - Graduation Year \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_

Mother's Name \_\_\_\_\_ Religion \_\_\_\_\_  
First Maiden Last

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Remarried

BBHS Alumna? \_\_\_ No \_\_\_ Yes - Graduation Year \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_

Student Resides With: \_\_\_ Both Parents \_\_\_ Mother \_\_\_ Father \_\_\_ Guardian \_\_\_ Other \_\_\_\_\_

Notes regarding custodial parent: \_\_\_\_\_

Other Children: Boys \_\_\_\_\_ Ages \_\_\_\_\_ Girls \_\_\_\_\_ Ages \_\_\_\_\_

**IN CASE OF EMERGENCY AND PARENTS CAN NOT BE REACHED PLEASE LIST ANOTHER CONTACT:**

\_\_\_\_\_  
Name Phone Relationship

\_\_\_\_\_  
Name Phone Relationship

FAMILY PHYSICIAN \_\_\_\_\_ Phone \_\_\_\_\_

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Please answer the following:

1. Please list any Physical Handicap(s) or illnesses. Example: Sight, Hearing, Diabetes, Etc. \_\_\_\_\_

\_\_\_\_\_

2. Please list any allergies. Example: Penicillin

\_\_\_\_\_

3. Do we have permission to send your child to a hospital should it be necessary? \_\_\_\_\_

Specific Hospital? \_\_\_\_\_

4. Do we have permission to give your child Tylenol/Advil? \_\_\_\_\_

Father's (Guardian) Signature \_\_\_\_\_

Mother's (Guardian) Signature \_\_\_\_\_

*Registration form must be accompanied by a \$100.00 non-refundable Registration fee.*