

\_\_\_\_\_  
(Signature – person completing form)

\_\_\_\_\_  
(Date)

### Trinity Catholic School Student Personal Information Form

This information you are asked to provide below will be used to continue the student's cumulative record which is the school's formal record of the student's growth from Kindergarten to Grade 6. The continual use of information in the student's cumulative record enable teachers, counselors and parents to better understand the student as an individual and thereby be in a much better position to give help according to individual needs.

1. Student name \_\_\_\_\_ Male \_\_\_\_\_  
Female \_\_\_\_\_

2. Student's date of birth \_\_\_\_\_ Place \_\_\_\_\_

3. Student's date of Baptism \_\_\_\_\_ Church \_\_\_\_\_ Place \_\_\_\_\_

4. Student's home phone \_\_\_\_\_ Address \_\_\_\_\_

5. If parents are separated,

a) Student lives with mother \_\_\_\_\_ or father \_\_\_\_\_

b) Legal custody is held by mother \_\_\_\_\_, father \_\_\_\_\_, or both \_\_\_\_\_

6. Student is a member of \_\_\_\_\_ Parish.

a) Father's religion \_\_\_\_\_

b) Mother's religion \_\_\_\_\_

7. Does the student have any of the following physical conditions or learning problems which the school should know about? Please check areas of parent concern.

\_\_\_\_\_ poor hearing

\_\_\_\_\_ heart condition

\_\_\_\_\_ poor speech

\_\_\_\_\_ poor vision

\_\_\_\_\_ diabetes

\_\_\_\_\_ asthma

\_\_\_\_\_ epilepsy

\_\_\_\_\_ learning difficulties

\_\_\_\_\_ other (\_\_\_\_\_)

8. Please provide the name of your family doctor or the doctor you want called in case of an emergency.

\_\_\_\_\_  
(Doctor's Name)

\_\_\_\_\_  
(Telephone Number)

## Family Information

If there are questions that you prefer not to answer, please leave it blank.

1. Student's father's name \_\_\_\_\_
2. Is student's father living \_\_\_\_\_ Deceased \_\_\_\_\_
3. Father's address \_\_\_\_\_ Phone \_\_\_\_\_
4. Father is employed by \_\_\_\_\_ Occupation \_\_\_\_\_
5. Highest grade completed by father: elementary \_\_\_\_\_ High school \_\_\_\_\_ College \_\_\_\_\_
6. Student's mother's name \_\_\_\_\_
7. Is student's mother living \_\_\_\_\_ Deceased \_\_\_\_\_
8. Mother's address \_\_\_\_\_ Phone \_\_\_\_\_
9. Mother is employed by \_\_\_\_\_ Occupation \_\_\_\_\_
10. Highest grade completed by mother: elementary \_\_\_\_\_ High school \_\_\_\_\_ College \_\_\_\_\_
11. Does the student have a step parent? \_\_\_\_\_
12. If yes, give step parent's name \_\_\_\_\_
13. Step parent is employed by \_\_\_\_\_ Occupation \_\_\_\_\_
14. Does student have a legal guardian (other than parents)? \_\_\_\_\_
15. If yes, give the guardian's name \_\_\_\_\_
16. Guardian's address \_\_\_\_\_ Phone \_\_\_\_\_
17. Guardian is employed by \_\_\_\_\_ Occupation \_\_\_\_\_
18. Language spoken in the home: English \_\_\_\_\_ Other languages \_\_\_\_\_
19. In the space below, give the first, month and year of birth of each of the student's brothers and sisters.

Brothers' first name & birth date

\_\_\_\_\_

\_\_\_\_\_

Sisters' first name & birth date

\_\_\_\_\_

\_\_\_\_\_

## Health and Social Development

The following information should be given as accurately as possible to help better understand your child.

1. Does your child have any known physical defects? \_\_\_\_\_  
If so, please describe. \_\_\_\_\_

2. Does your child need to have physical activities limited for any reason? \_\_\_\_\_  
If so, please describe. \_\_\_\_\_  
(If you answered yes, please send a statement from your physician to the office.)

3. Has your child ever been hospitalized? \_\_\_\_\_ If so, why? \_\_\_\_\_  
\_\_\_\_\_

4. Has your child ever experienced a severe emotional shock? (Auto accident, death, family upset, etc.) \_\_\_\_\_ If so, please describe \_\_\_\_\_  
\_\_\_\_\_

5. What type of discipline do you consider most successful with this child? \_\_\_\_\_  
\_\_\_\_\_

6. How does this child respond to discipline? \_\_\_\_\_

7. Please check any of the following symptoms which have been noted recently:

<input type="checkbox"/> 4 or more colds each year	<input type="checkbox"/> dizziness
<input type="checkbox"/> frequent sore throat	<input type="checkbox"/> fainting spells
<input type="checkbox"/> blurred vision	<input type="checkbox"/> abdominal pains
<input type="checkbox"/> running ears	<input type="checkbox"/> frequent pain in legs and joints
<input type="checkbox"/> frequent nose bleed	<input type="checkbox"/> night sweats
<input type="checkbox"/> tires easily	<input type="checkbox"/> hard of hearing

8. Please check which of the following you observe in your child:

<input type="checkbox"/> nail biting	<input type="checkbox"/> selfish	<input type="checkbox"/> becomes easily discouraged
<input type="checkbox"/> thumb sucking	<input type="checkbox"/> worries a great deal	<input type="checkbox"/> excitable
<input type="checkbox"/> bed wetting	<input type="checkbox"/> has many fears	<input type="checkbox"/> angers easily
<input type="checkbox"/> happy disposition	<input type="checkbox"/> is self reliant	<input type="checkbox"/> very easy to manage
<input type="checkbox"/> orderly	<input type="checkbox"/> dependable	<input type="checkbox"/> thoughtful of family members
<input type="checkbox"/> helpful around the house	<input type="checkbox"/> likes to play with others	<input type="checkbox"/> is generous with playmates

9. At what age did your child do the following?

Sit by himself \_\_\_\_\_ Walk holding onto things \_\_\_\_\_  
Walk unaided \_\_\_\_\_ Talk \_\_\_\_\_

10. At what time does he/she go to bed \_\_\_\_\_ What time does he/she get up \_\_\_\_\_

11. Does he/she rest during day? \_\_\_\_\_ What time? \_\_\_\_\_

12. Were there any complications or difficulties during delivery of this child?  
\_\_\_\_\_

13. Are there any problems or other matters which you would like to discuss with the school staff (administrator, psychologist, teacher, school nurse)?

14. Has your child had any of the following? If yes, what year?

- |  |  |
|--|--|
| _____ Chicken pox  | _____ Pneumonia                        |
| _____ Measles  | _____ Tuberculosis                     |
| _____ German measles   | _____ Tuberculosis in immediate family |
| _____ Mumps  | _____ Whooping cough                   |
| _____ Diphtheria   | _____ Running ears                     |
| _____ Scarlet fever  | _____ Infectious mononucleosis         |
| _____ Frequent sore throat                                   | _____ Frequent colds                   |
| _____ Rheumatic fever  | _____ Infectious hepatitis             |
| _____ Heart disease, - state type (congenital, Murmur, etc.) | _____ Operations – state type          |
| _____ Infantile paralysis                                    | _____ Tonsillectomy                    |
| _____ Frequent headaches                                     | _____ Epilepsy (Type _____)            |
| _____ Diabetes   | _____ Serious injury – state type      |
- \_\_\_\_\_

15. Is your child currently on any type of medication? If yes, please **list** the medical **condition**, the type of **medication** and the **amount** of dosage.

Medical condition \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Copies of the Birth Certificate, Baptismal Certificate (if baptized) and your child's immunization record need to be given to the school.