

# AUGUSTINIAN ACADEMY

## STUDENT APPLICATION GRADE 1-8

317 West Street, Carthage, NY 13619  
[www.caugustinian.org](http://www.caugustinian.org)

PHONE (315)493-1301  
FAX (315)493-0632

DATE: \_\_\_\_\_

GRADE ENTERING \_\_\_\_\_

### STUDENT INFORMATION:

Student Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Student Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
IF DIFFERENT THAN ABOVE

Home Phone Number: \_\_\_\_\_ Student SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
CITY STATE COUNTRY

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Religion: \_\_\_\_\_

School Last Attended: \_\_\_\_\_  
NAME GRADE

ADDRESS

### If Catholic:

Parish Registered/Attending: \_\_\_\_\_

Baptism Date \_\_\_\_\_ Church Baptized \_\_\_\_\_ City/State \_\_\_\_\_

First Penance Date \_\_\_\_\_ Church Received \_\_\_\_\_ City/State \_\_\_\_\_

First Communion Date \_\_\_\_\_ Church Received \_\_\_\_\_ City/State \_\_\_\_\_

Confirmation Date \_\_\_\_\_ Church Confirmed \_\_\_\_\_ City/State \_\_\_\_\_

### SIBLINGS

### GRADE

### DATE OF BIRTH

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

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

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

**PARENT INFORMATION:**

**Father's Name:** \_\_\_\_\_  
LAST FIRST MIDDLE

Mailing Address: \_\_\_\_\_  
IF DIFFERENT THAN STUDENT

SS# \_\_\_\_\_ Military (y/n): \_\_\_\_\_ Rank \_\_\_\_\_ Religion \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

EMAIL address: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_  
LAST FIRST MAIDEN

Mailing Address: \_\_\_\_\_  
IF DIFFERENT THAN STUDENT

SS# \_\_\_\_\_ Military (y/n): \_\_\_\_\_ Rank \_\_\_\_\_ Religion \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

EMAIL address: \_\_\_\_\_

**CHILD LIVES WITH:** \_\_\_\_\_ BOTH PARENTS \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_ OTHER

**PARENTS ARE:** \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SEPERATED \_\_\_\_\_ SINGLE

IF DIVORCED, WHO HAS LEGAL CUSTODY: \_\_\_\_\_

**EMERGENCY INFORMATION:**

\_\_\_\_\_  
NAME PHONE# RELATIONSHIP TO CHILD

\_\_\_\_\_  
NAME PHONE# RELATIONSHIP TO CHILD

CHILD'S PHYSICIAN \_\_\_\_\_  
NAME PHONE#

KNOWN ALLERGIES \_\_\_\_\_

**ETHNICITY** (Optional) If not completed, determination will be made by school for State compliance

American Indian/Alaska Native \_\_\_\_\_ Black/African American \_\_\_\_\_

Asian \_\_\_\_\_ Native Hawaiian/Pacific Islander \_\_\_\_\_ White \_\_\_\_\_

Multi-Racial \_\_\_\_\_

Is your child Hispanic, Latino, or of Spanish origin? Yes \_\_\_\_\_ No \_\_\_\_\_

**ADDITIONAL SERVICES:**

Does your child receive or has ever received:

IEP \_\_\_ 504 Plan \_\_\_ AIS Plan \_\_\_ Speech Therapy \_\_\_

Occupational Therapy \_\_\_ Physical Therapy \_\_\_

Has your child been diagnosed with ADD or ADHD? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever been home schooled? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when/how long? \_\_\_\_\_

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## REQUEST FOR RECORDS

PREVIOUS SCHOOL: \_\_\_\_\_ DATE: \_\_\_\_\_  
\_\_\_\_\_  
ADDRESS  
\_\_\_\_\_

PHONE# \_\_\_\_\_  
FAX# \_\_\_\_\_

Please forward academic records, health records and cumulative folder for the student(s) identified below, who have recently enrolled on our school. In addition, authorization has been given for the release of any individual academic or psychological evaluations, including Individual Education Plans.

NAME OF STUDENT	DATE OF BIRTH
_____	_____
_____	_____
_____	_____

I hereby request and authorize the release of all school records and files for the above student(s) to the Augustinian Academy School.

\_\_\_\_\_  
Signature-Parent/Guardian

\_\_\_\_\_  
Date

**PLEASE MAIL RECORDS TO:  
AUGUSTINIAN ACADEMY  
317 WEST STREET  
CARTHAGE, NY 13619**