Concordia Classical Academy
2101 Lor Ray Drive
North Mankato, MN 56003
Phone: 507.388.4336

Web: ccamankato.org
School Email: ccamankato@gmail.com

Student Application and Registration Form

Student Information

Date: _____ Entering Grade: _____

Student's Name: _____ Sex: M F Age as of Sept. 1st: _____
(Last) (First) (Middle)

Address: _____ County: _____
(Street) (City) (Zip)

Phone: (_____) _____ Date of Birth: _____ Place of Birth: _____
(City) (State)

Is the Child Baptized: Y N Date of Baptism: _____ Place of Baptism: _____

Church Membership of Parents: _____
(Church) (City) (State)

Last School Attended: _____

Address of School: _____
(Street) (City) (State) (Zip)

Last Grade Successfully Completed: _____ Teacher's Name: _____

Parent Information

Father's (Guardian's) Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____
(if different from student's) (Street) (City) (State) (Zip)

Employer: _____ Bus. Phone: _____

Address: _____ Email: _____
(Street) (City) (State) (Zip)

Mother's (Guardian's) Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____
(if different from student's) (Street) (City) (State) (Zip)

Employer: _____ Bus. Phone: _____

Address: _____ Email: _____
(Street) (City) (State) (Zip)

Marital Status: ___ Married ___ Divorced ___ Separated ___ Remarried ___ Other

Who does the child live with: _____

Sibling(s) Information

List Names and Birth Dates of Brothers and Sisters under age 21:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Does This Child Have Any Medical Problems That We Should Know About?

☐ Asthma ☐ Epilepsy ☐ Hemophilia ☐ Hay Fever ☐ Diabetes ☐ Dizziness ☐ Car Sickness

☐ Headaches ☐ Reaction to Bee Sting ☐ Nose Bleeds ☐ Food Allergies ☐ Fainting ☐ ADD/ADHD

☐ Special Education ☐ Other

Please Explain _____

_____

Reactions To Serum Drugs, or Other Medication? _____

Date of Last Tetanus Shot _____

Child's Dentist _____ Dentist Phone _____

Family Physician: _____ Phone: _____

Clinic Phone_____ Address _____

Name of Insurance Company _____ Policy Number _____

Emergency Contact Information:

Name of person(s) to be called in an **Emergency** when parents cannot be reached:

Name: _____ Home Phone: _____ Relationship to Student: _____

Address:_____ Cell Phone: _____

Name: _____ Home Phone: _____ Relationship to Student: _____

Address:_____ Cell Phone: _____

In case of accident or illness, permission is hereby given to treat or seek professional treatment for this child.

_____ _____

Parent Signature *Date*

CONCORDIA
CLASSICAL ACADEMY

Concordia Classical Academy Mission
The school, exists to help parents raise children (Ephesians 6:4), mature in body, mind and spirit who are fully equipped for good works in this life (2 Timothy 3:16-17) and to foster faith enduring to eternal life by sharing God's word in a Christ centered environment.

Please be sure your Curriculum and Registration Fee accompanies this form (if not already paid). Thank you!