

Good Shepherd Lutheran School - LCMS

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

Student Application and Registration Form

"Growing in Grace and Knowledge of our
Lord and Savior Jesus Christ" 2 Peter 3:18



Web: goodshepherdmandato.org
School Email: goodshepherd57@juno.com

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
- 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



Good Shepherd Lutheran School 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.