

APPLICATION FORM

ST. CHRYSOSTOM'S DAY SCHOOL

1424 N. Dearborn Parkway

Chicago, Illinois 60610

312.642.3422

312.642.2518

dayschooloffice@stchryds.org

Judy Caraher – Head of School

Mary Ellen Christy - Founder

Please Attach a Recent
Photograph of
Applicant
(OPTIONAL)

STUDENT DATA

CHILD'S

NAME: _____ Birthdate: ____ / ____ / ____
(Last) (First) (MI)

Child's Preferred Name: _____ Female (F) Male (M) _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

CHILD'S MOTHER or PARENT #1

NAME: _____
(Last) (First) (MI)

Profession or Title (If Applicable): _____

Company or Organization: _____

Business Telephone: _____ Cell Telephone: _____

E-Mail Address: _____

CHILD'S FATHER or PARENT #2

NAME: _____
(Last) (First) (MI)

Profession or Title (If Applicable): _____

Company or Organization: _____

Business Telephone: _____ Cell Telephone: _____

E-Mail Address: _____

For Office Use Only

Date Received: _____ Application Fee: _____

FAMILY DATA

Are you members of St. Chrysostom's Church? _____ Yes _____ No
(Two Year Prior to Application Date, Pledging and Communicant Member)

Have any family members attended St. Chrysostom's Day School? _____

<u>Siblings' Name</u>	<u>Siblings' Birthday</u>	<u>Siblings' School</u>
_____	____ / ____ / ____	_____
_____	____ / ____ / ____	_____
_____	____ / ____ / ____	_____
_____	____ / ____ / ____	_____

Marital Status of Parents: _____

Is child adopted? _____ If yes, age of adoption: _____ Has child been told? _____

Did child previously participate in a play group: _____ Hours per day: _____ # of days per week: _____

Please describe: _____

Did child previously attend another school: _____ Name of School: _____

Child's age at entrance: _____ Hours per day: _____ Number of days per week: _____

Please describe briefly the previous Sunday School or Day Camp experience your child has had: _____

Does your child have any special interest, abilities or handicaps: _____

Describe any illnesses, accidents and/or contagious diseases: _____

Was pregnancy full term? _____ Any birth complications? _____

If premature, is child being followed by a developmental therapist: _____

Does child have any allergies? _____

Name of child's Doctors: _____

Your Day School expectations and goals: _____

How did you hear about St. Chrysostom's Day School? _____

Please use the space below to indicate anything about your child, your family or yourself that you feel would have a significant bearing upon his/her school experience:

SIGNATURE of PARENT or GUARDIAN

PLEASE RETURN THIS APPLICATION TO:

ST. CHRYSOSTOM'S DAY SCHOOL

1424 N. Dearborn Parkway

Chicago, Illinois 60610

EMAIL: dayschooloffice@stchrysds.org

A physical examination is required for every student accepted and enrolled in the Day School Program.

This examination must be dated after July 1st of the year they are enrolled.

