

# BISHOP MCVINNEY SCHOOL

155 Gordon Avenue  
Providence, RI 02905  
401-781-2370  
www.bmv-school.org

<b>2019 - 2020</b>
<b>Registration Fee \$125</b>
<input type="checkbox"/> New Student
<input type="checkbox"/> Returning

**Application Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Entering Grade:** \_\_\_\_\_ **Age on 9/1/19:** \_\_\_\_\_

**Student's Legal Name:** \_\_\_\_\_ , \_\_\_\_\_  
*Last First Middle*

**Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Sex:**  Male  Female

**City of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
*Apt #, Street #, PO Box City State Zip*

**Student Lives With (check all that apply):**  Mother's Full Name: \_\_\_\_\_  
 Father's Full Name: \_\_\_\_\_  
 Legal Guardian\*: \_\_\_\_\_

\*Certificate of Guardianship Required

**Person Responsible for Tuition Payments:** \_\_\_\_\_  
*Full Name Phone #*

\_\_\_\_\_  
*Email Address*

Mailing Address: \_\_\_\_\_  
(check box if same as above)

**Emergency Contact #1:** Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Address: \_\_\_\_\_

**Emergency Contact #2:** Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Address: \_\_\_\_\_

**Medical Information:** Primary Care Doctor: \_\_\_\_\_  
Clinic: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Allergies/Medical Issues/Medicines: \_\_\_\_\_  
\_\_\_\_\_

