

WAIT LIST

CORPUS CHRISTI SCHOOL

2025-2026

2360 Waverley Ave. Van. B.C.
Email: office@cchristi.ca
604-321-1117

Entering Grade _____ in September 2025

FAMILY NAME _____

Please fill out and attach documents indicated below.

Email address: _____

Child's Legal Surname:					
Child's First Name:			Middle Names:		
Usual Names (if different from above)					
Street Address:			City:		
Postal Code:		Home Phone #:			
Child's Date of Birth:	Month:	Day:	Year:		
Child's Sex:	Male	Female			
Child's Birthplace: (Province of Canada or Country)					
Child's Religion:					
Baptism:	Yes	No	Reconciliation:	Yes	No
Communion:	Yes	No	Confirmation:	Yes	No
Primary language spoken at Home:		English:	Other:		
Indicate English Fluency:		Fluent	Good	Poor	
Father's Surname:		Mother's Maiden Name:			
Father's First Name:		Mother's First Name:			
If Father's/ Mother's phone # different from above, please provide:					
Father's Citizenship:		Mother's Citizenship:			
Father's Work Number:		Mother's Work Number:			
Father's Occupation:		Mother's Occupation:			
Father's Religion:		Mother's Religion:			
Parish You are registered in:			Envelope #		
If not parent, please indicate relationship & include legal guardian forms:					
Emergency Contact:			Phone Number:		
2 nd Emergency Contact:			Phone Number:		
Doctor's Name:			Doctor's Number:		
Dentist's Name:			Dentist's Number:		
Child's Personal Health #:					
Additional Information Required:		Please read and complete attached form.			
Last School Attended:					
Address:			Phone Number:		
COPIES OF THE FOLLOWING DOCUMENTS MUST BE PROVIDED WHEN RETURNING APPLICATION: BIRTH CERTIFICATE _____ BAPTISMAL CERTIFICATE _____ REPORT CARD _____ PROOF OF LEGAL RESIDENCY OF PARENT OR LEGAL GUARDIAN _____ (i.e. citizenship, landed immigrant papers or work visa etc.) LEGAL GUARDIAN FORM (if applicable) _____					

IMPORTANT AND HELPFUL INFORMATION

Family Name: _____

1. HEALTH CONDITIONS? ☐ YES ☐ NO

Does your child have any potential, life-threatening medical conditions? Please check one or more of the following:

Allergies (Anaphylaxis/Severe Allergic Reaction) to _____

Does the child carry and EpiPen? ☐ YES ☐ NO

Anxiety/Depression

Asthma

Diabetes

Epilepsy/Seizure

Heart Condition

Other potential, life-threatening medical condition, please specify:

2. SPECIAL NEEDS? ☐ YES ☐ NO

Does your child have any special needs? Please check one or more of the following:

Visual Impairments

Deaf or Hard of Hearing

Deaf/Blind

Autism Spectrum Disorder

Intellectual Disability

Learning Disability

Behavioral Needs

Physically Dependent

Physical Disabilities/ Chronic Health Impairments

Gifted

Speech Impediment

Other

Please specify

3. COPING SKILLS

- ☐ YES ☐ NO Follows routines and expectations
- ☐ YES ☐ NO Manages transitions and changes in routine
- ☐ YES ☐ NO Tolerates frustration appropriately
- ☐ YES ☐ NO Consistently separates easily from parents or caregivers
- ☐ YES ☐ NO Uses the toilet independently
- ☐ YES ☐ NO Demonstrates age-appropriate dressing and eating skills

In order to provide a safe and productive learning environment, it is imperative that pertinent information is disclosed to the school for educational planning purposes. Acceptance is contingent upon appropriate disclosure of relevant information to the school. Disclosure of this information WILL NOT AFFECT your child's admission. **All information provided will be kept confidential.**