



St. Cronan's Junior National School

Scoil Chrónáin Naofa

Brackenstown, Swords, Co. Dublin, K67 DP28. Telephone: (01) 8402194
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SCHOOL ADMISSION APPLICATION FORM

Date of Application: Class/Start Date:

Child's Name: Male Female

Date of Birth: P.P.S. Number:

Child's Nationality: Language spoken at home:

Religion: Eircode:

Address:

Parent/Guardian 1

Parent/Guardian 2

Name: Name:

Occupation: Occupation:

Nationality: Nationality:

Home Telephone: Home Telephone:

Mobile: Mobile:

Work Number: Work Number:

Status: Married Single Widowed Cohabiting Separated Other

Emergency contact name and number: (should Parents/Guardians be unavailable)

1. Name: Contact No:

2. Name: Contact No:

Name of preschool/school child has attended:

If another school please state which class/year group:

Have you other children in St. Cronan's Junior or Senior School? Yes No

If yes Name of child: Class:

Name/Address/Telephone number of Family Doctor:

Has your child, for whom you are making an application for a school place, any;

1. Medical condition?

2. Learning difficulty?

3. Behavioural difficulty?

4. Assessment completed?

5. Assessment in process?

(If yes to any of the above please supply a copy of any report available. This is for information purposes only to enable us to support the child and will not affect admission)

Is there any legal order under Family Law which the school should be aware of? Yes No

If yes please explain:

Please provide a copy of any court orders.

Do you wish your child to be prepared for sacraments of Penance and First Communion? Please sign.

Yes: No:

If yes please supply a baptismal certificate.

If 'No' may your child attend church as an observer? Yes No

May your child participate in formal Roman Catholic religion classes? Yes No

Have you any worries, concerns or additional information you would like us to be aware of?

It is school policy to contact parents in the case of any serious accident /illness during school hours.

Should you be unavailable the school will act in the best interests of the child.

I authorise the school to act in what the school considers to be the best interests of my child in seeking medical attention.

Please state who will be collecting your child from school and give mobile numbers for them:

Name: Mobile:

Name: Mobile:

Signed:

Parent(s)/Guardian(s): and

OFFICE USE ONLY:

Documents received:

Birth Certificate Baptismal Certificate Proof of Address P.O.D. Form
Reports Medical Form

Aimn: Start Date:

P.O.D. ID No.: Date of leaving: