ST. CATHERINE OF ALEXANDRIA REGISTRATION FORM

When registering:

- **You will need to complete one application form for each child registering.**
- **Include a copy of your child(s) official birth certificate.**
- **Include a copy of your child(s) baptismal certificate.**
- **Include a copy of your child(s) communion certificate (if your child is in 3rd - 8th grade).**
- **A review of records must be completed from previous school for transfer applications in Grades 2nd - 7th.**
- **A Release of Records Form must be signed if your child has attended another school.**
- **A registration fee of $100.00 per family (non-refundable) is required with your application.**
- **Medical and dental forms must be submitted before the first day of school.**

ENTERING GRADE _____ **REGISTRATION DATE ____/____/_____**

CHILD'S NAME _____
LAST NAME FIRST MIDDLE

ADDRESS _____
CITY STATE ZIP CODE

CHILD IS: [ ] MALE [ ] FEMALE

DATE OF BIRTH ____/____/_____ BIRTHPLACE _____

RELIGION (PLEASE CHECK): ROMAN CATHOLIC _____ OTHER RELIGION _____

RESIDING WITH: [ ] MOTHER [ ] FATHER [ ] BOTH [ ] OTHER_____
Please provide custody agreement, if applicable.

RACE: *Check all that apply* ( ) African-American ( ) Native-Hawaiian/Pacific Island ( ) Alaskan Native
( ) Native American ( ) Asian ( ) Caucasian Hispanic/Latino Y ( ) N ( )

MOTHER'S NAME _____
FIRST LAST

MAIDEN NAME_____

RELIGION _____ **OCCUPATION _____**

MOTHER'S CELL PHONE NUMBER _____ MOTHER'S EMAIL _____

HOME PHONE NUMBER (if different from cell phone number) **_____**

FATHER'S NAME _____
FIRST LAST

RELIGION _____ **OCCUPATION _____**

FATHER'S CELL PHONE NUMBER _____ FATHER'S EMAIL _____

HOME PHONE NUMBER (if different from cell phone number) **_____**

STUDENT SACRAMENT INFORMATION

BAPTIZED: **[ ] YES [ ] NO ____/____/____**

DATE CHURCH NAME CITY STATE

FIRST COMMUNION: **[ ] YES [ ] NO ____/____/____**

DATE CHURCH NAME CITY STATE

RECONCILIATION: **[ ] YES [ ] NO ____/____/____**

DATE CHURCH NAME CITY STATE

CONFIRMED: **[ ] YES [ ] NO ____/____/____**

DATE CHURCH NAME CITY STATE

REGISTERED
PARISHIONER: [ ] YES [ ] NO* PARISH REGISTRATION DATE ____/____/____ ENVELOPE # _____

***INDICATE OTHER PARISH NAME: _____**

MEDICAL CONDITIONS: _____

ALLERGIES: _____

AUTHORIZED MEDICINE(S): _____

DOES YOUR CHILD HAVE AN IEP/ICEP/504 PLAN? [ ] YES [ ] NO IF YES, PLEASE PROVIDE A COPY OF PLAN

TRANSFERRED FROM:

SCHOOL NAME **STREET** **CITY** **STATE** **ZIP CODE**

PLEASE INDICATE PRESCHOOL CHOICE (IF APPLICABLE)

ALL STUDENTS MUST BE FULLY TOILET TRAINED PRIOR TO BEGINNING SCHOOL

3 YEAR OLD (PLEASE CHECK)

_____	3	HALF DAYS	8:00 A.M. - 11:00 A.M.	TUESDAY, WEDNESDAY, THURSDAY
_____	5	HALF DAYS	8:00 A.M. - 11:00 A.M.	MONDAY - FRIDAY
_____	3	FULL DAYS	8:00 A.M. - 2:45 P.M.	TUESDAY, WEDNESDAY, THURSDAY
_____	5	FULL DAYS	8:00 A.M. - 2:45 P.M.	MONDAY - FRIDAY

4 YEAR OLD (PLEASE CHECK)

_____	5	HALF DAYS	8:00 A.M. - 11:00 A.M.	MONDAY - FRIDAY
_____	3	FULL DAYS	8:00 A.M. - 2:45 P.M.	TUESDAY, WEDNESDAY, THURSDAY
_____	5	FULL DAYS	8:00 A.M. - 2:45 P.M.	MONDAY- FRIDAY

PARENT/LEGAL GUARDIAN NAME (PLEASE PRINT): _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____