Holy Spirit Catholic School
Student Registration

Complete form (front & back)

SCHOOL YEAR: 2024-2025

ENTERING GRADES:

Child's Name	DOB	Sex
1: _____	__/__/__	__M __F
2: _____	__/__/__	__M __F
3: _____	__/__/__	__M __F
4: _____	__/__/__	__M __F

Primary Address

Street: _____

City: _____Zip_____

Secondary Address

Street: _____

City: _____Zip: _____

Parent Info:

Father's Name: _____
Cell Phone: _____Work:_____
E-Mail: _____
Occupation:_____

Mother's Name: _____
Cell Phone: _____Work:_____
E-Mail: _____
Occupation:_____

Resides with *(check one)*

Both ☐ Mother ☐

Father ☐ Other ☐: _____

Does other parent have shared custody?
Yes ☐ No ☐

Ethnic Origin of Child

(This is used for State/Diocesan statistical purposes.)

☐ Caucasian ☐ Hispanic

☐ African-American ☐ Asian/Pacific Islander

☐ Native American ☐ Multi-Racial

Language spoken at home: _____

US Citizen _____YES _____NO

Is your child Catholic? ☐ Yes ☐ No

If yes, was your child Baptized in a Catholic Church? ☐ Yes ☐ No

Please check all the sacraments your child has received in the Catholic Church:

☐ Penance ☐ Holy Eucharist
☐ Confirmation

Parishioner? ☐ Yes ☐ No
If no, what Church do you attend? _____
_____

Academic Information

***Kindergarten Use Only**: Did the student attend VPK? ☐Yes ☐No

Has the student ever repeated a grade? ☐Yes ☐No

If so, which Grade(s)?_____

Has the student ever been suspended/expelled from any school? ☐Yes ☐No

Psychological if Applicable

Please submit psychological test results

☐ N/A ☐ ADD ☐ ADHD
☐ SLD Please list disability_____

Is your child taking any medication associated with this disability?
☐ Yes ☐ No
If yes, please specify: _____

_____

Medical Information

Is student currently taking medication on a regular basis? If yes, please specify in the box below.

Prescription (medication prescribed by a physician)

Diagnosis (i.e. Asthma)	Medication	Dosage	Frequency

Non-Prescription (over-the-counter medication)

Condition	Medication	Dosage	Frequency

*I give school office staff permission to give Tums or Tylenol to my child if needed. YES_____NO_____
Medication forms are available in the office.

Does your child have any allergies? _____If yes, please specify: _____

_____

Does your child have asthma? _____ Current treatment: _____

EMERGENCY CONTACT_____PHONE_____

Family Doctor_____ Preferred Hospital_____

The following information must be enclosed with the application: (<u>For New Students Only</u>)

- **Birth Certificate**
- **Baptismal Certificate (Catholic)**
- **Recent report card and previous two years report cards (if applicable)**
- **Standardized Tests (grades 3-8)**
- **Psychological Test Results (if applicable)**

I, _____

(Print First & Last Name)

acknowledge that I have completed the application, student enrollment and medical information forms to the best of my knowledge. If any information changes, I will notify the school office in writing as soon as it occurs.

_____ _____

Signature **Date**

<u>Florida Department of Health</u>

****OFFICIAL USE ONLY****

☐ Student Health Examinations (Gold/Yellow Form)

Date: _____

☐ Certificate of Immunization (Blue Form)

Completed: _____ Date to be completed by: _____