



# HOLY TRINITY CATHOLIC SCHOOL

Application for Admission for School Year \_\_\_\_\_ - \_\_\_\_\_

Application Accepted: \_\_\_ Yes \_\_\_ No

Principal's Signature: \_\_\_\_\_

## STUDENT'S INFORMATION:

Please Circle – Applying for Grade:		PreK3, FT (3 or 5 days) PreK3, PT (3 or 5 days) PreK4 K 1 2 3 4 5 6	Date of Birth:		
Child's Full Name:	First	Middle	Last	Suffix (Jr., III, etc.)	
Place of Birth:		Sex:		Race	
Social Security Number:					
Child's Religion:		Baptized?	___ Yes ___ No		
Parish Church (Name, City, State)		Does the applicant have a sibling attending this school?			
Marital Status:		Custody:			
Applicant Lives with:		Legal Guardian (if different than parents)			

## FATHER'S INFORMATION:

Father's Full Name:	Title	First	Middle	Last
Street Address:		City	State	Zip
Telephone Numbers	Home	Work	Cell	Email
	Fax	Religion		
Occupation		Employer's Name, City and State		
Step-Mother's Name (If Applicable)		Step-Mother's Cell Phone:		

## MOTHER'S INFORMATION:

Mother's Full Name:	Title	First	Middle	Last
Street Address:		City	State	Zip
Telephone Numbers	Home	Work	Cell	Email
	Fax	Religion		
Occupation		Employer's Name, City and State		
Step-Father's Name (If Applicable)		Step-Father's Cell Phone:		

## LEGAL GUARDIAN'S INFORMATION (If different from parents):

Guardian's Full Name:	Title	First	Middle	Last
Street Address:		City	State	Zip
Telephone Numbers	Home	Work	Cell	Email
	Fax	Religion		
Occupation		Employer's Name, City and State		

**PERSON(S) FINANCIALLY RESPONSIBLE FOR THE APPLICANT:**

Name:		Relationship to Student:		
Street Address:		City	State	Zip
Telephone Numbers	Home	Work	Cell	Email

**PAST SCHOOL RECORD**

Name of School	Full Address	Phone	Fax	Grade(s) Attended	Reason Left

Has your child ever been expelled from any school?

**INFORMATION FOR EMERGENCY OR MEDICAL CARE**

Please list any allergies or major medical problems (asthma, diabetes, heart trouble, epilepsy, etc.)

Please describe any special health or learning needs of your child:

Emergency Contact (In case parents or guardians can't be reached):	Home Phone	Work Phone	Cell Phone

Relationship to Student:		Employer/Occupation:	
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Student's Physician's Name:		Physician's Phone Number:	
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Any additional information you would like to share about your child/family:

Please list any special instructions regarding custody or visitation:

Persons authorized to check student out of school:

Persons not authorized to check students out of school:

Parent Signature:	Date:
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Parent Signature:	Date:
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Registration Fee: \_\_\_\_\_  
\_\_\_\_\_ Birth Certificate    Amount    \_\_\_\_\_ Check#/Cash    \_\_\_\_\_ Date Rcvd    \_\_\_\_\_ Received By  
\_\_\_\_\_    \_\_\_\_\_ Social Security Number    \_\_\_\_\_ Last Report Card (if transferring)  
\_\_\_\_\_    \_\_\_\_\_ Baptismal Certificate    \_\_\_\_\_ Health Compliance Form