Visitation Catholic STEM Academy
PRE-Kindergarten Registration
Monday – Friday, 8:05 am – 3:00 pm

Please attach $40.00 Non-Refundable Application Fee per Family

STUDENT INFORMATION			
Last Name	First Name	Middle Name	
Home Address	City/State/Zip		
Birthdate	Birth Place	Sex	Current Age

Child resides with: ___ Both Parents ___Mother ___Father ___Guardian ___Other Arrangement

Parental Marital Status: ___ Married ___Widowed ___Divorced ___Separated Who has legal custody?_________________

Child is: ___Adopted ___Foster Child ___Natural ___Other

FATHER/GUARDIAN **Catholic _____ yes _____ no Registered in ____________________________ Parish**

Last Name	First Name	Phone (H)
Home Address	City/State/Zip	
Employer/Occupation		Work Phone
Email	Pager	Cell Phone

MOTHER/GUARDIAN **Catholic _____ yes _____ no Registered in ____________________________ Parish**

Last Name	First Name	Phone (H)
Home Address	City/State/Zip	
Employer/Occupation		Work Phone
Email	Pager	Cell Phone

SIBLING INFORMATION

Ages of siblings attending Visitation Catholic STEM Academy

Ages of siblings not attending Visitation Catholic STEM Academy

SCHOOL APPLICATION

Most recent school attended if applicable:

Name of local neighborhood school (for reporting purposes)

How did you hear about Visitation Catholic STEM Academy?

STUDENT SACRAMENTAL INFORMATION:

Baptism Date	Church	City/State/zip

EMERGENCY CONTACT INFORMATION - Local Contacts Only Please

Persons to contact in case of an emergency (if parent/guardian cannot be reached) and who are authorized to pick up the student at school.

Emergency Contact Person 1	Work Phone	Home Phone	Relationship
Emergency Contact Person 2	Work Phone	Home Phone	Relationship
Babysitter/Daycare Name	Address		Phone Number
Local Physician	**Address**	**Zip code**	**Phone Number**
Date of last physical			
Local Dentist	**Address**	**Zip code**	**Phone Number**

Ethnic Background for Reporting Purposes (optional). Please check one:

___Native American ___Asian ___Black ___Hispanic ___Hawaiian / Pacific Islander ___ White (not Hispanic origin)

Are you aware of any learning, physical or emotional difficulties with you child/ren? _____yes _____no If yes, please explain:

Special Medical Information or Instructions (ie: allergies, asthma): If yes, we will need appropriate documentation on file with a with a licensed physician's signature confirming the child's disability and appropriate substitutions.

Grandparents' name and address (to mail newsletter and other school mailings)

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Signature : ______________________________ Date: ______________________________