

REGISTRATION FORM 2025-2026

STUDENT INFORMATION									
Student's last name:			First:		Middle:			Grade:	
Street address:					Home phone no.: ()				
City:					State		ZIP Code		
Place of Birth:					Date of Birth / /			Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Baptism <input type="checkbox"/> Yes <input type="checkbox"/> No		Baptism Church:			City, State			Baptism date: / /	
Communion <input type="checkbox"/> Yes <input type="checkbox"/> No		Communion Church			City, State			Comm. Date: / /	
Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No		Confirmation Church			City, State			Confirm Date / /	
Previous School					ICS Church/Parish #:		Religion		
Language Spoken at Home:			Ethnicity		Scholarships				
Oldest Child CURRENTLY at ICS <input type="checkbox"/> Yes <input type="checkbox"/> No			Marital status (circle one) Single / Mar / Div / Sep / Wid			Custodial Parent:			
Father's last name:			First:		Middle:			Place of Birth:	
Street address (If different from Student)					Personal Email:				
City:			State		Zip Code		Work Email:		
Place of Employment				Job Title/ Position			Are you an alumni: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Maiden last name:			First:		Middle:			Place of Birth:	
Street address (If different from Student)					Personal Email:				
City:			State		Zip Code		Work Email:		
Place of Employment				Job Title/ Position			Are you an alumni: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Step-Mother's Name			Step-Father's Name			Student's Social Security Number			
EMERGENCY CONTACT INFORMATION									
Father's Phone Numbers: Work: () Cell: ()					Mother's Phone Numbers: Work: () Cell: ()				
Emergency Contact Person			Relationship to Student:		Home phone no.: ()		Work phone no.: ()		
Emergency Contact Person			Relationship to Student:		Home phone no.: ()		Work phone no.: ()		
Emergency Contact Person			Relationship to Student:		Home phone no.: ()		Work phone no.: ()		
Doctor's Name:					Office phone no.: ()		Other phone no.: ()		
Allergies:									
Dismissal: <input type="checkbox"/> Parent/Relative Pick-up <input type="checkbox"/> After School Program <input type="checkbox"/> Walk Home <input type="checkbox"/> Carpool with: _____									
How did you hear about our school:									
The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.									
_____ Patient/Guardian signature					_____ Print Name			_____ Date	

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