

REGISTRATION FORM 2026-2027

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.: ()
Emergency Contact Person		Relationship to Student:	Home phone no.: ()
Emergency Contact Person		Relationship to Student:	Home phone no.: ()
Doctor's Name:		Office phone no.: ()	Other phone no.: ()

Allergies:

Dismissal: Parent/Relative Pick-up After School Program Walk Home 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