Holy Cross Catholic School
K-6 REGISTRATION 2025-2026

Student Legal Last Name	Student First Name	M.I.	Preferred Name	24-25 Grade	DOB	Gender	Race

Student(s) Information

Address_____ City_____ Zip_____

Local School District: _____

Primary Telephone: _____ Number for Text Alerts: _____

Email address for school communications_____

**Student information is available to other parents. If you would prefer to have your child's information excluded from the roster, please mark here: _____*

***Has your student been baptized, if so at what parish: _____**

City: _____ State: _____ Date if known: _____

Billing Information

Name of parent/guardian responsible for tuition: _____

Address _____City _____ Zip_____

Primary Telephone: _____ Primary Email Address_____

SCHOLARSHIPS/ SUBSIDY / FINANCIAL AID INFORMATION (not applicable for Pre-K)

Please check all that apply:

__ I/We are applying for one or more scholarships or financial aid.

__ I/We are applying for a Catholic School Tuition Subsidy.

(Subsidies will be considered after scholarship eligibility/financial aid applications are considered.)

__ I/We waive the right to apply for a Catholic School Tuition Subsidy or other scholarship aid.

__ I/we will pay the full cost of tuition.

TUITION PAYMENT INFORMATION (Payment Begins August 15)

__ I will pay tuition in full by August 31, 2025 (Tuition paid in full will receive a 2% discount).

__ I will pay tuition by Monthly Direct Withdraw beginning in August 2025.

__ Please bill me monthly for tuition.

(A one-time $40 processing fee will be applied per student for monthly billing.)

PLEASE SEE OTHER SIDE OF FORM

Caregiver Information

Student Lives With: _____Mother _____Stepmother _____Legal Guardian
_____Father _____Stepfather

If Parents Are Divorced/Separated, Who Has Legal , Court Appointed Custody:_____

Is There A Restraining Order? (Yes) ____ (No)____ Against Whom? _____

_____ _____
Father's or Guardian's name Phone Number

_____ _____
Father's Workplace Work Phone Number

_____
Father's Email

_____
Father/Guardian Signature

_____ _____
Mother's Name (First & Maiden) Phone Number

_____ _____
Mother's Workplace Work Phone Number

_____
Mother's Email

_____
Mother/Guardian Signature

Return registration form along with:
Non-refundable $25 registration fee (per student)
Copy of Birth Certificate (only required for newly enrolled students)
Copy of Immunization Records (only required for newly enrolled students)
Media Release (only required for newly enrolled students)
Health History Form (only required for newly enrolled students)
Dismissal Instructions (only required for new students unless changes have been made)
Updated Medical Authorization form (all students)

HCCS admits students of any religion, race, color, national and ethnic origin to all rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of religion, race, color, national and ethnic origin in administration of its educational policies, admissions policies, scholarship and loan programs, and athletic and other school-administered programs.

Holy Cross Catholic School

Emergency Medical Authorization

(2025-2026)

Student Name: _____ Grade _____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact:

Mother's name _____ Phone # _____

Mother's employers name _____ Phone # _____

Father's name _____ Phone # _____

Father's employers name _____ Phone # _____

People to be contacted in the event of an emergency if the parent cannot be reached:

Name _____ Phone # _____ relationship to child _____

Name _____ Phone # _____ relationship to child _____

We have been unsuccessful; I hereby give consent for:

(1) the administration of any treatment deemed necessary by:

_____ _____ or _____ _____

(Preferred Physician) (Phone) (Preferred Dentist) (Phone)

or in the event the designated-preferred practitioner is not available, by another licensed physician or dentist; and

(2) the transfer of the child to _____ _____

(Preferred Hospital) (Phone)

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted.

Signature: _____ _____ _____

(Parent/Guardian) (Address) (Date)

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PART II REFUSAL TO CONSENT

(Do not complete Part II if you completed Part I)

I do not give my consent for emergency medical treatment for my child in the event of illness or injury requiring emergency treatment. I wish the school authorities to take no action or to:

_____

Signature: _____ _____

(Parent/Guardian) (Date)

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Dismissal Instructions

Please return this form to the office by the first day of school

Parent Name/Guardian: _____

My child(ren)_____, is a car rider.

Listed below are names of 3 people who have my permission to pick up my child(ren).

1) _____ _____
Name Phone Number

2) _____ _____
Name Phone Number

3) _____ _____
Name Phone Number

_____ is a bus rider and will ride bus #_____

to _____ after school.
(Address of Destination)

_____ will walk to
_____ after school.
(Address of Destination

If the procedure for dismissal is different on a given day, I will send a dated, handwritten note with my child for the office.

_____ _____
Parent/Guardian Signature Date

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AUTHORIZATION FOR MEDIA RELEASE

_____ _____

Student name Date

There are times during the school year when the news media, community organizations, school related organizations, or school personnel may ask to interview, photograph, and/or videotape our students.

Throughout the year various activities or programs may be videotaped and aired on our local television station. A newspaper may ask to take pictures and interview students of our school about school related news. If we are partnering with an organization (Defiance College, Glenn Park, iHeart radio, etc.) they may take pictures of the activity and want to share on their network media. There may also be times when pictures or videos of students' school activities will be posted on the school's web page.

By signing the acceptance below you are granting Holy Cross Catholic School of Defiance the right to use, copyright, publish and incorporate photographs or video footage taken of your child as a result of his/her participation in approved activities of the school through various methods of the media without reservation or compensation.

This authorization will remain in effect indefinitely unless otherwise revoked by the undersigned. I understand that I have the right to revoke this authorization at any time by submitting a written request to the school principal. This revocation will be effective, except to those actions already taken in reliance on my authorization.

I have read this form and fully understand the contents, meaning, and reason for this release.

AGREED TO AND ACCEPTED THIS _____ DAY OF _____, 20___.

_____

Signature of Parent or Guardian

I hereby revoke this authorization effective as of

_____

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /