HCCS
Holy Cross Catholic School

Pre-K Registration Form
(2025-2026)

STUDENT INFORMATION

Name _____(nickname)_____ Birth date: _____
**Roster information is available to other parents. If you would prefer to have your child's information excluded from the roster, please check here:* ____
Address_____ City_____ Zip_____
Local School District: _____
Primary Telephone: _____ Family Email Address: _____

***Has your student been baptized, if so at what parish: _____**
City: _____ State: _____ Date if known: _____

My child will need before school care. My child will need after school care (all day 4's only)

My child will ride a bus (circle all that apply): to school | from school | some days | everyday

I am registering my child for the following Pre-K program:

___	All Day, Everyday Young 5's	8:30 - 3:10 (5 yr. old by Sept. 30th)	$2500/yr
___	Mon-Wed-Fri (all day)	8:30 - 3:10 (4 yr. old by Sept. 30th)	$2500/yr
___	Tues-Thurs (1/2 day)	8:30 - 11:30 (3 yr. old by Sept. 30th)	$1200/yr

SCHOLARSHIPS/ SUBSIDY / FINANCIAL AID INFORMATION (not applicable for Pre-Kindergarten)
This information is required for all applicants. 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 at a rate of $2500 per student (Young 5's)

PAYMENT INFORMATION
Please check all that apply. This information will be used to prepare your Tuition Payment Agreement.

I will pay my owed amount 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 $45 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 Occupation Work Phone Number

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

_____ _____
Mother's Occupation Work Phone Number

Other children in family:

Name	Grade
_____	_____
_____	_____
_____	_____

I give my permission to have my name, address, email and telephone number printed in the school roster.

_____
(Signature)

Thank you for Choosing Holy Cross Catholic School for your family!
Please return registration form along with
non-refundable $25 registration fee (per student) to Holy Cross Catholic School.

The following forms are included in this packet and need completed and returned by the first day of school.

- Emergency Medical Form
- Family Information Sheet
- Health History Form
- Student After School Pick-Up form
- Copy of Birth Certificate (only required for newly enrolled students)
- Copy of Immunization Records (only required for newly enrolled students)
- Media Release Form
- Child Medical Statement form

HCCS admits students of any 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 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.

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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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INFORMATION SHEET 2025-2026

Full Name_____ Birth Date _____
Name to be used at school _____
Parents/Guardians' Names _____
Marital status of parents _____ Child lives with _____

Does your child have any brothers or sisters? YES NO (If yes, please list)

NAME	AGE	SCHOOL

Is another language spoken at home? YES NO _____
Has your child ever attended preschool prior to Holy Cross? YES NO
Has your child ever attended Story Hour at the library? YES NO
Does your child have playmates his/her own age? YES NO
Has your child had experience with crayons, pencils, and markers? YES NO
Has your child had experience with scissors? YES NO
Does your child have any special interests or hobbies? _____
Does your child have any allergies or physical challenges? YES NO

_____

_____

Does your child take any medication on a regular basis? YES NO

_____

Is your child aware of dangers such as fire, traffic and strangers? YES NO

_____

At what age did your child:
Walk alone _____ Talk in sentences _____
Is your child right or left handed? RIGHT LEFT NOT SURE
Does your child dress him/herself? YES NO SOME
Could you help with an in-school party? YES NO
Could you drive for a field trip? YES NO
Please list any additional comments or information about your child that may be helpful in working with you and your child.

_____

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PRE-SCHOOL PROGRAM

Pick- Up Form

(2025-2026)

For your child's protection, please fill out the name of authorized persons to bring, or take your child from our Pre-Kindergarten program, other than yourself.

Please inform the authorized persons to be prepared to identify themselves to our staff. Please list parent other than one signing this, if authorized to pick up.

NAME: _____ RELATION TO CHILD: _____

NAME: _____ RELATION TO CHILD: _____

NAME: _____ RELATION TO CHILD: _____

NAME: _____ RELATION TO CHILD: _____

Please inform us whenever changes are in order

In case of a car pool arrangement, designate such on the line "relationship" or tell us here what the arrangements will be: _____

_____

Is there anyone who might stop for your child that you do NOT wish to have your child released to (other parent, for instance)?

_____ _____

_____ _____

Signature: _____ Date: _____

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
		/ /

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 3/12/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		Exempt from Immunization:	
Complete for Age	○ Yes ○ No	Religious Conviction	○ Yes ○ No
In Process	○ Yes ○ No	Health	○ Yes ○ No
		Other	

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.