



Pre-K Registration Form (2024-2025)

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:

Table with 3 columns: Program Name, Time, and Fee (TBD/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.
I/We waive the right to apply for a Catholic School Tuition Subsidy or other scholarship aid.

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, 2023.
I will pay tuition by Monthly Direct Withdraw beginning in August 2023.
Please bill me monthly for tuition.

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.*



Holy Cross Catholic School
Emergency Medical Authorization
(2024-2025)

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:

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Signature: \_\_\_\_\_ (Date) \_\_\_\_\_  
(Parent/Guardian)



**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

\_\_\_\_\_



INFORMATION SHEET 2024-2025

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.



Holy Cross Catholic School  
PRE-SCHOOL PROGRAM  
Pick- Up Form  
(2024-2025)

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: \_\_\_\_\_



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

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, Health, and Other.

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

Large empty rectangular box for entering health conditions.

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.



Ohio Department of Health • School and Adolescent Health  
**Health History**

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /    /
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**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> <b>NO</b> medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> 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
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> 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 / /
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