

HOLY CROSS CATHOLIC SCHOOL APPLICATION

Student Name: _____ M ___ F ___ Grade _____ Age _____

D.O.B. _____ SS# _____ Language(s) Spoken At Home _____

Home Address _____
Street City Zip

Phone # _____ School Last Attended _____

Student's Religion _____ Church Attending _____

U.S. Citizen: Yes ___ No ___ Country of Birth _____

Father's Name _____ Single Separated Married
First M Last Deceased Remarried Divorced

Religion _____ Occupation _____

Business Address _____ Phone _____
Street City Zip

Father's Education High School College Other

Father's E-Mail Address _____

Mother's Name _____ Single Separated Married
First M Last Deceased Remarried Divorced

Religion _____ Occupation _____

Business Address _____ Phone _____
Street City Zip

Mother's Education High School College Other

Mother's E-Mail Address _____

If Applicable:

Guardian _____ Phone # _____ Relationship to Student _____

Student's Legal Address _____
Street City Zip

Public School Which Student Would Attend _____ District _____

Date of Entry _____ Grade Entering _____

	BAPTISM	FIRST HOLY COMMUNION	CONFIRMATION
CHURCH			
DATE			
CITY, STATE			

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ADDENDUM TO THE APPLICATION FORM

Describe any tutoring or special education programs the child is receiving or has received.

Describe any special needs of the child of which the school be aware. (Educational, health, etc.)

Name(s) of children in the family and name of school each attends.

Name

School

Name

School

Name

School

Name

School

Parent/Guardian Signature

Please return completed form to:

Office Manager

Holy Cross Catholic School

2001 Katy Avenue

Bay City, TX 77414

Fax Number: (979)245-6120

You will receive a phone call to arrange an interview.

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Dear Parent:

Each year the Office of Catholic Schools as well as each individual school is required to provide information to the National Catholic Education Association pertaining to the racial/ethnic demographics of our students. It is not the place of school officials to designate individuals. It is appropriate that parents designate the one category among those listed below that best describes their family background. Please assist us by providing the required information on this form.

Thank you for choosing to educate your child/children in a Catholic school in the Diocese of Victoria.

Sincerely,

John E. Quarry
Superintendent of Schools

- Asian:** identifies as having origins in Far East, Southeast Asia or Indian Sub-continent; (Cambodia, China, India, Korea, Malaysia, Pakistan, Philippines, Thailand, Vietnam, etc.)
- American Indian/Native American:** identifies as one of the two classifications of Native Americans
- Black/African American:** identifies as black whether from the U.S., Africa or other parts of the world
- Hispanic:** identifies as of Hispanic origin
- Native Hawaiian/Other Pacific Islander:** includes native Hawaiians living anywhere in the U.S. (but not non-Hawaiian residents of Hawaii); also includes other Pacific Islands: Guam, Samoa, Fiji, Micronesia, Polynesia
- White:** Caucasian from any part of the world (including Middle East) that does not identify as one of the other groups
- Multi-racial:** person belongs to more than one racial group

Family Name: _____

Name(s) of children enrolled in this school:

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HEALTH QUESTIONNAIRE AND PERMISSION FOR TESTING PROGRAMS

Student _____ Birth _____
 Last Name First Middle Date _____ Phone _____

Parents _____ Address _____

Physician _____ Phone # _____

Dentist _____ Phone # _____

Please provide a date for any illnesses your child has had.

ILLNESS	DATE	ILLNESS	DATE
Allergy		Pneumonia	
Asthma		Poliomyelitis	
Back Injury		Rheumatic Fever	
Chicken Pox		Scarlet Fever	
Diabetes		Serious Injury	
Ear Infections		Surgery	
Epilepsy		Tonsillitis	
Head Injury		Tuberculosis	
Hearing Loss		Vision Loss	
Measles		Whooping Cough	
Other			

If your child is on medication, please refer to the “Medication Policy” in the Student-Parent Handbook regarding the dispensing of medication in school.

IMMUNIZATION DOCUMENTATION: According to the Texas Department of Health guidelines, any document will be acceptable, provided it has been validated by a physician or public health personnel.

PERMISSION FOR TESTING PROGRAMS

Permission is given this date _____, for my child _____ to participate in the Health Program at Holy Cross Catholic School, to include **EYES, EARS, SCOLIOSIS SCREENING, AND GENERAL HEALTH CHECKS.** This permission continues in effect until revoked.

Parent/Guardian Signature: _____ Date _____