IMMACULATE CONCEPTION SCHOOL
REGISTRATION FOR K – 6th GRADE
2024-2025 SCHOOL YEAR

Date of Registration: _____

Current Parish: _____

Transfer: ___ Y ___ N If yes, please list previous school: _____

STUDENT INFORMATION:

(Please list students youngest to oldest)

Student Names:	Sex	Birth Date	Ethnicity *(see below)	Grade (2024-2025)
_____	M F	___/___/___	_____	_____
_____	M F	___/___/___	_____	_____
_____	M F	___/___/___	_____	_____
_____	M F	___/___/___	_____	_____

*Please use the following chart for ethnicity: Alaska Native=**AL** American Indian=**AI** Asian=**A**
Black/non-Hispanic=**BL** Hispanic=**H** Native Hawaiian /Pacific Islander=**NH** White, non Hispanic=**W**

PARENT INFORMATION:

Mother (or guardian)

Name_____

Email _____

Address_____

City_____ St____ Zip_____

Home Phone _____ Cell_____

Employer_____ Work Phone_____

Father (or guardian)

Name_____

Email _____

Address (if different)_____

City_____ St____ Zip_____

Home Phone _____ Cell_____

Employer_____ Work Phone_____

Status of Parents: ___ Married ____ Separated ____ Divorced ____ Remarried ____ Father Deceased ___ Mother Deceased

Please list any special arrangements you want us aware of:_____

_____

Names and ages of siblings not enrolled at IC School:_____

_____

EMERGENCY CONTACTS:

Please list someone other than parent or guardian; we will **always** attempt to contact parents first. These names should be someone who would be available to make decisions on your behalf.

Name: _____ Phone: _____

Name: _____ Phone: _____

EMERGENCY/MEDICAL INFORMATION:

Name of Family Physician: _____ Clinic:_____ Phone: _____

Please explain any special medical needs/allergies_____

Special Education Needs: _____

☐ I UNDERSTAND IT IS MY RESPONSIBILITY TO SUBMIT HEALTH SERVICES REQUEST FORMS A & B IF MY CHILD HAS A FOOD OR OTHER ALLERGY THAT WOULD REQUIRE A SPECIAL DIET OR CARE. THESE FORMS MUST BE COMPLETED BY PARENTS AND CHILD'S PHYSICIAN ANNUALLY.

PARENTAL CONSENT:

____ I hereby consent to any medical services that may be required while my child is under the supervision of an employee of Immaculate Conception School and hereby appoint an Immaculate Conception Employee to act on my behalf in securing necessary medical services from any duly licensed physician or medical emergency provider. Responsibility for payment of ambulance, physician and/or hospital is that of the parent or guardian.

____ I release school personnel from any liability in relation to the administration of medical care plans. Immaculate Conception School acknowledges that its personnel have limited or no knowledge of administering health related services.

____ IC School staff is authorized to access the South Dakota State Immunization website to obtain current immunization information for my child(ren).

BAPTISMAL INFORMATION:

Child's Name	Baptism Date	Parish	City, State
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____

1ST COMMUNION INFORMATION:

Child's Name	Date	Parish	City, State
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____

TUITION INFORMATION:

- A non-refundable $50.00 deposit per family is required at the time of registration for grades K-6. This deposit will be applied towards tuition at the beginning of the school year.
- I understand that all tuition payments are due by the 10th of the month.
- I agree that by the end of the current school year I will have paid all tuition and lunch/milk fees in full.
- I verify that all information provided on this form is accurate to the best of my knowledge; I have read, understand and agree with all statements on this form.

Signed (Parent/Guardian): _____ Date: _____