



# HOLY ANGELS CATHOLIC ELEMENTARY SCHOOL

230 North 8th Avenue • West Bend, WI 53095  
(262) 338-1148 www.has.pvt.k12.wi.us

Office use only:

Date Received: \_\_\_\_\_

## GENERAL INFORMATION:

Student's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Number/P.O. Box/Street  
\_\_\_\_\_  
City/State/Zip Code

Email: \_\_\_\_\_

Student's Religion: \_\_\_\_\_

Ethnic Background:

\_\_\_\_ American Indian/Native Alaskan \_\_\_\_ White  
\_\_\_\_ Black \_\_\_\_ Hispanic \_\_\_\_ Multi-racial  
\_\_\_\_ Asian \_\_\_\_ Native Hawaiian/Pacific Islander

Parish Membership: \_\_\_\_\_

## FAMILY INFORMATION:

Father's Name: \_\_\_\_\_  
Last First Middle

Father's Date of Birth: \_\_\_\_\_

Father's Religion: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Last First Middle (Maiden)

Mother's Date of Birth: \_\_\_\_\_

Mother's Religion: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

If there is a divorce or legal separation, which parent has legal custody of the child? \_\_\_\_ Father \_\_\_\_ Mother \_\_\_\_ Joint Custody

## REGISTRATION FORM: K3 PROGRAM

Date of Birth: \_\_\_\_\_ M/ \_\_\_\_ F

Place of Birth: \_\_\_\_\_  
(City/State)

Telephone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Education Level: \_\_\_\_\_

Telephone Number (daytime): \_\_\_\_\_

Occupation: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Education Level: \_\_\_\_\_

Telephone Number (daytime): \_\_\_\_\_

If neither parent has custody, who does have custody? \_\_\_\_\_

If either parent is restricted from having contact with child, please explain: \_\_\_\_\_

If this is a "blended family" which includes persons other than the child's natural parents, please briefly describe: \_\_\_\_\_

If the student has received medical or psychological attention (other than routine examinations), please explain: \_\_\_\_\_

The child's siblings are:

<u>Name</u>	<u>Birthdate</u>	<u>Is the sibling presently living at home?</u>
_____	_____	___ Yes / ___ No
_____	_____	___ Yes / ___ No
_____	_____	___ Yes / ___ No

**SESSION SELECTION: Please mark your 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> choice**

\_\_\_\_\_ 3-day (MWF) Half-Day Program (7:45-11:00am)

\_\_\_\_\_ 3-day Full-Day Program (7:45-2:50pm)

\_\_\_\_\_ 5-day (M-F) Half-Day Program (7:45-11:00am)

\_\_\_\_\_ 5-day Full-Day Program (7:45-2:50pm)

\_\_\_\_\_ I am interested in the extended care program (full day only).

*(Note: The usual class limit is 16 students; sessions will be offered only if enough students register to make it economically feasible to offer the session.)*

**ATTESTATION:**

I certify and attest that the above information and statements are complete and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Father/Legal Guardian

\_\_\_\_\_  
Signature of Mother/Legal Guardian

Date: \_\_\_\_\_

Date: \_\_\_\_\_