



St. Thecla School  
6323 N. Newcastle  
Chicago, Il 60631

## New Student Registration Form

### STUDENT INFORMATION

Name: \_\_\_\_\_  
Last First Middle

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Sex: Male / Female Age as of September 1, 2017: \_\_\_\_\_ Grade: \_\_\_\_\_

(Preschool Only): Full Day / Half Day Days: MWF / MTWThF

Catholic: Yes / No

Transferred From: \_\_\_\_\_ Grade Last Attended: \_\_\_\_\_  
Name of Previous School

### PARENT INFORMATION

#### Mother's Information

Mother's Name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Home Phone: \_\_\_\_\_ Mother's Cell Phone: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_ Mother's E-mail: \_\_\_\_\_

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

Is mother an alumna of St. Thecla? Yes / No

PARENT INFORMATION (Continued)

Child's Name: \_\_\_\_\_

Father's Information

Father's Name: \_\_\_\_\_

Father's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_ Father's Cell Phone: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ Father's E-mail: \_\_\_\_\_

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

Is father an alumnus of St. Thecla?      Yes /      No

Parent Status:      Married/Living together      Separated      Divorced      Deceased

Child Lives With:      Mother and Father      Mother      Father      Other

If other, please explain:

Parishioner's of St. Thecla:      Yes /      No      Envelope Number: \_\_\_\_\_

Did a current St. Thecla family refer you? If so, who:

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

For office use only: Registration fee paid: Amount: \_\_\_\_\_ Check # \_\_\_\_\_      Cash      Other

Please continue to next page  
(Emergency Contacts)

Child's Name: \_\_\_\_\_

## EMERGENCY INFORMATION

Emergency Contact #1:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Emergency Contact #2:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Phone Number: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Allergies:      Yes      No

If yes, to what:

Other Medical Considerations: