**Holy Angels of the Hudson Valley Registration Form 2020-2021**

**7 Cozzens Avenue; Highland Falls, NY 10928 845-446-6741 holyangelsofthehv@gmail.com**

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| **STUDENT INFORMATION** |
| **Full Name of Student:** |  |
| **Grade for 2018-2019:** | **Age 3(preschool) Age 4(PreK) K****Part Time Full Time**  | **Date of Birth****(M/D/YEAR)** |  |
| **Address:** |  | **Email:** |  |
| **Main Phone:** |  | **Alternate Phone:** |  |
| **Resident School District:** |  **HFFMCSD West Point Other:** | **IEP/504 Plan?**  | **If Yes, please attach to registration.** **Y N** |
| **Main Point of Contact & Relationship:** |  | **Religion:** |  |
| **Ethnicity (required by NYS)** | **Asian Black Caucasian Hispanic/Latino Multiracial American Indian/Alaskan Native Native Hawaiian/Pacific Islander** |

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| **Permissions** |
| Permission to photograph student in educational setting/field trips for use in advertising, press releases, yearbook, and social media. | **Y N Initial Here:** |
| Permission to walk with class to local library 1X a week (grades PreK-K/1st) | **Y N Initial Here:** |
| Permission for walking field trips to local sites (e.g. post office, florist, firehouse, museums, local businesses) | **Y N Initial Here:** |
| Permission to share contact information for school directory | **Y N Initial Here:** |
| Emergency Contact Name and Phone Number (1)\*Grants permission to pick up from school in emergency/illness | Emergency Contact Name and Phone Number (2)\*Grants permission to pick up from school in emergency/illness |
| In addition, permission for the following people to pick up from school grounds (such as carpooling): |
| **Page 2 HAHV Application for:** |
| **FAMILY INFORMATION** |
| **Father’s First and Last Name:** | **Mother’s First and Last Name:** |
| **Address, if different from child** | **Address, if different from child** |
| **Custody? Permission to Release from School? Y N** | **Custody? Permission to Release from School? Y N** |
| **Religion** | **Religion** |
| **Preferred Phone Number:** | **Preferred Phone Number:** |
| **Alternate Phone:** | **Alternate Phone:** |
| **Email:** | **Email:** |
| **Occupation:** | **Occupation:** |
| **Employer:** | **Employer:** |
| **If Military, Rank:** | **If Military, Rank:** |
| **Name and Age/Grades of Sibling(s):** |
| **MEDICAL AND EMERGENCY INFORMATION** |
| **Medical Insurance:** | **Hospital Choice:****Keller Army Community Hospital St. Luke’s Cornwall****Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Family Physician’s Name:** | **Physician Phone:** |
| **Family Dentist:** | **Dentist Phone:** |
| **Allergies and/or Medical Conditions:** | **Medications:** |

**This form was completed by (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*Please submit: Health Physical (must be within one year), Vaccination Records, Registration Fee and First Month Payment**