



Enrollment Form

2024-2025

109 W. Fourth Street
Port Clinton, OH 43452
Phone: 419-734-3315
Fax: 419-734-6172

Student Last Name: _____ Student First Name: _____
Enrolling in Level: _____ Date of birth: _____
Mailing Address: _____ Male or Female: _____
City/State/Zip: _____ City & State of Birth: _____
Present Grade: _____ Previous School: _____

Will this child use AM/PM Kids Care: Y/N? _____ Will this child use Preschool Leap Time program: Y/N? _____

Custodial Family Information

<input type="checkbox"/> Father	<input type="checkbox"/> Stepfather	<input type="checkbox"/> Other	<input type="checkbox"/> Mother	<input type="checkbox"/> Stepmother	<input type="checkbox"/> Other
Last Name: _____			Last Name: _____		
First Name: _____			First Name: _____		
Home Phone: _____			Home Phone: _____		
Cell Phone: _____			Cell Phone: _____		
Email: _____			Email: _____		
Occupation: _____			Occupation: _____		
Employer: _____			Employer: _____		
Business Phone: _____			Business Phone: _____		

Race/Ethnicity: Please check the box that applies.

- Asian
- American Indian/Native Alaskan
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White
- Two or more races

Siblings:

Name	Birthdate	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there a Court Order pertaining to child custody in place for this student? Yes No

If yes, Docket #: _____

Please attach most current copy.

Religious Affiliation

_____ Catholic

_____ Non-Catholic/Other Religion:
_____ (Please specify)

Name of church attending:

I certify the information provided is accurate & current for this student.

Parent/Guardian Signature Date