

DIVINE MERCY ACADEMY

Application for Admission

A non-refundable deposit of \$120.00 per family is due at the time of registration.
Copies of immunizations, birth and baptismal certificates must be submitted at time of application.

STUDENT'S INFORMATION

Child: _____
(Last Name) *(First)* *(Middle)*

Date of Birth: _____ Place of Birth: _____ Sex: ___ Male ___ Female

Entrance Grade: _____ Entrance Date: _____ Transfer from: _____
(Name of School) *(City/State)*

For Pre-K Families Only: Number of Days Attending: _____ Half-Day or Full-Day: _____

Days of the week your child will be attending Divine Mercy Academy: _____

Sacrament	Church	Location	Date
Baptism			
First Communion			
Penance			

FATHER'S INFORMATION

Name: _____
(Last Name) *(First)* *(Middle)*

Occupation: _____

Religion: _____ Place of birth: _____

Home Street Address: _____

City, State, Zip: _____

Home phone: _____

MOTHER'S INFORMATION

Name: _____
(Last Name) *(First)* *(Middle)*

Occupation: _____

Religion: _____ Place of birth: _____

Home Street Address: _____

City, State, Zip: _____

Home phone: _____

Marital Status: _____ If applicable, who is the custodial parent/guardian? _____

If Catholic, what parish are you a member of? _____

Parent/Guardian Signature: _____ Date: _____

For Office Use Only:
Amount Paid: _____ Check#/Cash: _____ Date: _____ Received By: _____

Birth Certificate ___ Baptism Certificate ___

Immunization Records ___

DIVINE MERCY ACADEMY
September 2018 to June 2019

Family Name: _____

Child: _____	Grade: _____	Date of Birth: _____
Child: _____	Grade: _____	Date of Birth: _____
Child: _____	Grade: _____	Date of Birth: _____
Child: _____	Grade: _____	Date of Birth: _____

Father's name: _____
Father's occupation: _____
Father's email: _____
Father's work phone: _____ Cell phone: _____

Mother's name: _____
Mother's occupation: _____
Mother's email: _____
Mother's work phone: _____ Cell phone: _____

Home Street Address: _____
City, State, Zip: _____
Home phone: _____

IN THE EVENT A PARENT CANNOT BE REACHED, PLEASE CALL THE FOLLOWING AND THEY HAVE PERMISSION TO PICK UP MY CHILD/CHILDREN:

NAME: _____ PHONE NUMBER: _____
NAME: _____ PHONE NUMBER: _____
NAME: _____ PHONE NUMBER: _____

Remarks: _____

Allergies / Conditions:

Child's Physician: _____ Physician's phone #: _____