



REGISTRATION FORM

Please complete and return to the school office at the following address or return at the time of your guidance appointment.

304 E. Roadway Ave. • Effingham, Illinois 62401

Ph 217.342.6969 • Fax 217.342.6997 • www.stanthony.com

For Office Use
Student ID: _____

Today's Date: ___/___/___

Student's Last Name _____ First _____ Middle _____ Nickname _____ Entering Grade _____ Male

If not entering St. Anthony High School on the first day of the school year please specify date of entry: _____ Female

Address _____ City _____ ST _____ Zip _____ Home Phone _____

Social Security Number _____ Date of Birth _____ Place of Birth _____

Student's Email Address _____

Father/Guardian Information: Mr. Dr. Other _____ Active military service? Yes No

First Name _____ Last _____ Address _____ Home Phone _____

Religion _____ City _____ ST _____ Zip _____ Cell Phone _____

Occupation _____ Employer _____ Work Phone _____

Email Address _____ Include my email address for receiving school news: Yes No

Married Divorced Separated Remarried Single Deceased

Mother/Guardian Information: Miss Mrs. Ms. Dr. Other _____ Active military service? Yes No

First Name _____ Last _____ Address _____ Home Phone _____

Religion _____ City _____ ST _____ Zip _____ Cell Phone _____

Occupation _____ Employer _____ Work Phone _____

Email Address _____ Include my email address for receiving school news: Yes No

Married Divorced Separated Remarried Single Deceased

In case of emergency when parents are not available, call:
Emergency Contact: _____ Phone: _____

Student's Religious Affiliation _____ Parish You Now Attend _____ City _____

Last School Attended _____ Address _____

Has the student repeated any grade? Yes No If yes, please specify _____

Has the student received any special education or speech services? Yes No If yes, please specify _____

Student resides in Public School District Unit # _____

Does student ride a bus? Yes No

If yes, over 1 1/2 miles Under 1 1/2 miles

Please list any special health concerns _____

Family Physician: _____ Phone # _____



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RECORD RELEASE FORM

Date: _____

I hereby authorize the Registrar, Office Staff, or Secretary and _____ School
(Name of Sending School)

to release all information (Health, Psychological, Social Services) in the school records of

_____. With this permission, I also release
(Student Name)

_____ School from all liability and all claims pertaining to the
(Name of Sending School)

disclosure of this information.

**Please send records to: St. Anthony High School
 304 E Roadway Avenue
 Effingham IL 62401**

Signature: _____
(Parent/Guardian)