



2024-25 Returning Student Registration for Re-Enrollment

Annual Tuition: \$15,475

Application Fees \$625 OR \$775 (Itemized below)

____ \$100 Non-refundable Early Bird Registration Fee (available January 2024 only) OR

____ \$250 Non-refundable Registration Fee (After 2:00 PM on January 31, 2024)

____ \$525 Program Fee (Covers dress-down shirts, agenda, folders, disposable workbooks, one yearbook, club/elective classes, access to software at home and school, and field trips.)

Please fill out and submit with your deposit to secure a seat.

Student Name: _____

Birth Date: _____

Parent SSN for scholarships: _____

Race/Ethnicity: _____

Seeking Grade: _____

Do you have a psychoed evaluation? _____

Gender: _____

(please circle) YES NO ↩

Primary Mailing Address: _____

Have you ever received a Step Up for Students Scholarship? _____

If so, please provide the ID#: _____

Primary Phone Numbers: _____

Diagnosis: Please list all of your child's learning differences and medical conditions.

Family and Custody Information

Mother/Primary Caregiver's Name: _____ Mother's Phone: _____

Mailing Address (if different from primary): _____

Mother's Employer and Occupation: _____ Work Phone: _____

Mother's E-mail (checked daily): _____

Mother's Custody Arrangement (full, partial, etc.; please provide documentation): _____

Father/Primary Caregiver's Name: _____ Father's Phone: _____

Mailing Address (if different from primary): _____

Father's Employer and Occupation: _____ Work Phone: _____

Father's E-mail (checked daily): _____

Father's Custody Arrangement (full, partial, etc.; please provide documentation): _____

Additional Medical Information/Emergency Information

Hospital Location of Choice: _____ Hospital Phone: _____

Medical/Allergy Alerts (major conditions not already listed): _____

Note: Emergency contacts also have permission to pick up your student in nonemergency situations.

Emergency Contacts (other than primary caregivers listed above)

Name: _____ Phone: _____

Name: _____ Phone: _____

(Initial) _____ I assume full financial responsibility for emergency care and/or transportation for said child and will not hold the school financially responsible.

Doctor Name: _____ Dr. Phone: _____

Student Health Insurance: _____

Policy Number: _____ Group Number: _____

Parents of students with asthma and/or allergies only: please initial if true*
(Initial) _____ I, the undersigned, choose **not** to keep an inhaler for my child in the DePaul office.*
(Initial) _____ I, the undersigned, choose **not** to keep an Epi-Pen for my child in the DePaul office.*

(Initial) _____ I, the undersigned, authorize DePaul School to contact directly the persons named on this form and authorize the named physician to render treatment as is necessary in an emergency for the health of the child. In the event parents cannot be contacted, DePaul School staff is authorized to take whatever action is necessary in their judgment for the health of the child. I will assume full financial responsibility for emergency care and/or transportation for said child and will not hold the school financially responsible.

Prescription Medication: If your child requires prescriptions, please fill out the separate form and have it signed by your child’s doctor. Please make every effort to dispense prescriptions to your child outside of school hours. If you cannot, please fill out the separate form. *All prescriptions must be in the original bottle with a current prescription date and correct information.*

Non-Prescription Medication: Please request a Medication Permissions form from the office, fill out, and return with a doctor’s signature. You must also provide any medication we give your child, including vitamins and cough drops.

Pickup/Release Information:

I give permission to DePaul School to release my child to the following person(s) during the 2023-24 school year (in addition to primary caregivers):

Name as appears on Driver’s License: _____ DOB: _____

Name as appears on Driver’s License: _____ DOB: _____

Name as appears on Driver’s License: _____ DOB: _____

Name as appears on Driver’s License: _____ DOB: _____

Student Behavioral Survey

Please answer the following questions truthfully and thoroughly.

Name of Student: _____

In the last 3 years, has your child received any Needs Improvement or unsatisfactory marks in conduct or behavior? Were you called to pick up your child from school due to behavior? Please describe.

Does your child have referrals for behavior/conduct? Please describe.

Is there anything else about your child's behavior that could affect his/her experience at DePaul?

I understand that DePaul is not a school that remediates behavioral issues or truancy. I further understand that my child must follow the DePaul Code of Conduct while a student at DePaul; work to resolve conflicts peacefully, behave honestly and respectfully with students/teachers in person and online, refrain from distracting other students, follow adult directives to go to class, cooperate with staff, and follow all rules in the current edition of the Student Handbook, including that he/she must attend class when asked.

I further understand that tardies, early checkouts, and excessive absences may affect my child's success in the program, and their ability to attain and keep scholarships.

If I falsify this document or fail to disclose behavioral information that negatively affects my child's or another student's DePaul experience, or if my child does not display growth when redirected, my student will be removed from the school.

I have read and understand 4/4 pages of this document.

Parent signature

Date