



U.S. Virgin Islands Department of Education

STUDENT DEMOGRAPHIC INFORMATION

St. Thomas-St. John District

Public School Registration

STUDENT INFORMATION

Student's Full Name: _____
Last Name First Name Middle Name

School and Grade Placement determined by the Office of Student Services Sex: Male Female

Date of Birth: _____ Place of Birth: _____ US Citizen: Yes No

Home Language: _____ Primary Language: _____ Hispanic: Yes No

Race (Check all that applies to student)

Asian Black American Indian/Alaska Native
Native Hawaiian/Pacific Islander White

Program (Check all that applies to student)

Regular Special Education
504 Program English as a Second Language

Residence Address: _____
Street Address City State Zip Code

Mailing Address: _____
Local PO Box/Street Address City State Zip Code

Home Phone: _____ Mobile: _____ Alt Phone: _____

PARENT/GUARDIAN INFORMATION

Full Name: _____ Relationship: _____

Resides with Student: Yes No Address (if different from above): _____

Marital Status: Single Married Divorced Widowed Place of Birth: _____

Nationality: US Citizen Permanent Resident Naturalized Citizen Work Permit None

Home Phone: _____ Mobile: _____ Work Phone: _____

Employer: _____ Email: _____

Full Name: _____ Relationship: _____

Resides with Student: Yes No Address (if different from above): _____

Marital Status: Single Married Divorced Widowed Place of Birth: _____

Nationality: US Citizen Permanent Resident Naturalized Citizen Work Permit None

Home Phone: _____ Mobile: _____ Work Phone: _____

Employer: _____ Email: _____

STUDENT DEMOGRAPHIC INFORMATION CONTINUED

PRESCHOOL INFORMATION

Status: Head Start Home Private Pre School/Day Care: _____

PREVIOUS SCHOOL INFORMATION

Last School Attended: _____ Grade: _____

Mailing Address: _____
PO Box/Street Address *City* *State* *ZipCode*

HEALTH INFORMATION

(Please check any health conditions and/or allergies that your child suffers from or may be experiencing.)

Allergies	Diabetes	Heart Condition	Migraine Headaches	
Asthma	Epilepsy	Leukemia	Physical Limitations	Others

1. _____ 3. _____
2. _____ 4. _____

Special Circumstances: _____

Doctor/Clinic: _____ Phone Number: _____

Student has Health Insurance: Yes No Medical Insurance Carrier: _____

SIBLINGS ATTENDING PUBLIC SCHOOLS IN DISTRICT

Sibling 1: _____	Relationship: _____	School: _____
Sibling 2: _____	Relationship: _____	School: _____
Sibling 3: _____	Relationship: _____	School: _____
Sibling 4: _____	Relationship: _____	School: _____

OTHER EMERGENCY CONTACTS

Contact 1: _____	Relationship: _____	Telephone: _____
Contact 2: _____	Relationship: _____	Telephone: _____
Contact 3: _____	Relationship: _____	Telephone: _____

(Save and/or Print this form for your records before submitting.)

District Contact Information: (340) 775-2250 OR sttregistration@vide.vi

Kindly inform the school your child attends of any future changes to student's demographic information.

FOR DISTRICT USE ONLY

Entry Date: _____ Entry Code: _____ School Assigned: _____

District Personnel: _____