

For Office Use	
Family Name: _____	
School Year: _____	
Fee: _____	Check #: _____

Religious Education Program Registration Form Presentation BVM

Complete Form. Print clearly. For first time registrations, please provide one copy of each child's Baptismal Certificate.

Child's Full Name (First, Middle, & Last)	Sex M/F	Date of Birth	Grade Level	Name and Phone Number of Day School	Baptism Date & Parish	1 st Penance Date/Parish	1 st Communion Date/Parish

Family Name: _____ Home Phone #: _____

Address: _____ Street _____ City _____ Zip Code _____ Email: _____

Father's Name: _____ Work or Cell Phone #: _____ Religion _____

Mother's Name: _____ Work or Cell Phone #: _____ Religion _____

- Name of Person* responsible for Religious Education if not Parent/Guardian _____ Relationship _____
 *Please provide a letter signed by a parent/guardian which gives permission and names this person as the one responsible for the child(ren)'s religious education.
 Please check box if there are custodial/legal issues regarding any child listed above.

DIRECTORY (DO YOU WANT YOUR NAME ADDED TO THE LIST?) YES NO

VOLUNTEER(PLEASE CHECK) TEACHER, SUBSTITUTE _____ AIDE _____
 _____ **3:30PM SCHOOL YARD** _____ **WEEKLY CLASSROOM**
 _____ **5:00PM SCHOOL YARD** _____ **MONTHLY CLASSROOM**

PLEASE TURN TO PAGE 2

EMERGENCY CONTACT INFORMATION:

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IN ORDER TO FACILITATE ANY EMERGENCY MEDICAL TREATMENT THAT MAY BE NEEDED,

If we are unable to reach you, whom should we contact?

Name: _____ Relationship: _____ Phone Number
(home) _____

(cell) _____

CONSENT FOR MEDICAL CARE:

I give permission that, in my absence, my children whose names appear on page 1 of this registration form, may receive emergency medical care for injuries and all situations that should occur while participating in the Religious Education Program programs and activities at **(PRESENTATION)** Parish.

Signed (Parent/Legal Guardian): _____ Date: _____

MEDICAL/LEARNING DATA

If any of the following apply to your child, please list his/her name and give details in the appropriate spaces.

Child's Name	Medical Conditions/Allergies	Prescribed Medications	Disability/Learning Support Services	Individualized Education Program IEP
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

Is there other information about your child that should be communicated? _____

Please remember to send us your check by September 2 or a late fee of \$150.00 per child will be charged.