2018-2019
Saint Richard Parish School of Religion Registration Form
ONE FORM PER CHILD

Child's Last Name _____ **First Name** _____

Home Address _____

City_____ Zip _____ Date of Birth _____

Primary Phone _____ Alternate Phone _____

Primary E-Mail_____

Secondary E-Mail _____

Father _____ Religion _____
First & Last name

Mother _____ (_____) Religion _____
First & Last Name Maiden Name

If parents are divorced/ separated who is custodial parent? _____
****If child is NOT to be picked up by Parent please inform PSR office****

Name of Guardian (**if not parents**) _____ Religion _____

School Attending _____Grade in School/PSR 2018-2019_____

Parish Registered and actively involved at _____

SACRAMENTAL INFORMATION - *(Please turn in a NON RETURNABLE copy of certificates with this form)

Baptism Parish _____ Date of Baptism _____

City/State of Baptism Parish _____

First Communion Parish _____ Date of Communion _____

City/State of Communion Parish _____

PSR fee is $50 per child PAYABLE WITH REGISTRATION! Please hand registrations in by June 18, 2018. If your family is experiencing financial difficulty at this time, please contact the Religious Education Office (779-7529) for consideration regarding alternative financial resolution.

****MEDICAL RELEASE ON BACK OF FORM – MUST BE COMPLETED ALONG WITH REGISTRATION**

Emergency Medical Authorization 2018-2019

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under the authority of the Parish School of Religion when parents/guardians cannot be reached.

Part I **OR** Part II **must** be completed and returned to the Religious Education Office.

Part I (To grant consent)

Child's Name: _____ **Age:** _____ **Grade:** _____

In the event reasonable attempts to contact me at _____(phone) or other parent/guardian at (phone) have been unsuccessful, I hereby give my consent for **(1)** the administration of any treatment deemed necessary by Dr. _____ (preferred doctor/phone) or Dr. _____ (preferred dentist/phone) or in the event the designated preferred physician is not available, by another licensed physician or dentist; and **(2)** the transfer of the child to _____ (preferred hospital) or any reasonably accessible hospital.

This authorization does not cover any major surgery unless the medical opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted. If none please write "none known at this time."

_____ _____

Date Parent/Guardian Signature

_____

Address

Please list the name(s), the relationship and phone number(s) of person(s) we might call in case of an emergency or sickness and you are not home.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

DO NOT complete this part if you completed Part I

Part II (Refusal to Consent)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or emergency treatment required, I wish the school authorities to take no action or to:

_____ _____

Date Parent/Guardian

_____

Address