Dear Parents,

Attached is a copy of the St. Patrick Religious Education Program registration form. One form per family is necessary.

The fee is $35.00 per child; You may pay when you return the form or on the first day of classes.

We would like to publish a list of students in each class with their phone numbers, addresses, and parents' names. The purpose of this listing is to help families get to know who is in their child's religion class and encourage families to develop friendships with others in the program.

In order to publish this list, we need your permission to publish your name, address and phone number. Please complete the form below and RETURN it with your child's registration form.

If you have any questions, please feel free to call.

Thanks,
Kathleen Lipka – CCD Coordinator
454-4664

_____ I give my permission to publish our names, address, phone number, & child's name.

_____ I do not give my permission to publish our names, address, phone number, & child's name.

_____ You may include my child's name, but not our names, address, or phone number.

Family Name: _____

Mother's Maiden Name: _____

Child/Children's Name: _____

Email Address: _____

Signature: _____

Historic St. Patrick Religious Education Registration 2018-2019

1209 W. Locust St
Bloomington IL 61701

Family Last Name: _____

Mailing Address: _____

City: _____ Zip Code: _____

Home Phone number: _____ Unlisted? Y N

Registered at Historic St. Patrick Church? Y N

Parents

Relationship to Child:_____ Relationship to Child:_____

Name:_____ Name:_____

Cell Phone Number:_____ Cell Phone Number:_____

Email:_____ Email:_____

Religion:_____ Religion:_____

Mother's maiden name:_____

Emergency Information

In the event of an emergency, please contact the following (other than parents):

Name:_____

Relationship:_____

Phone Number:_____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the parish. A copy will be distributed to the person in charge of each trip or athletic activity in which the student participates. Should the need arise this information will be given to the proper medical authorities. I understand that in the case of illness or injury to my child, the school will try to notify me or the person I have listed as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited tom, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility. This authorization for Emergency Medical Treatment is valid for one year, from August 1, 2018 through July 31, 2019.

Signature of Parent/Guardian: _____ Date: _____

Turn Over for Student Information

Student Name:_____ Birthdate:_____ Sex: M F

Grade:_____ School:_____ Language: _____

Date Place of Sacrament Address of Church (Baptism only)

Baptism: ___/___/____ _____ _____

Reconciliation: ___/___/____ _____

First Communion: ___/___/____ _____

Confirmation: ___/___/____ _____

Student Medical and Emergency Information

Physician: _____ Phone: _____

List any medical conditions of the student: _____

_____

List any allergies or allergic reactions: _____

_____

List any medications the student is presently taking: _____

Other pertinent medical information: _____

Insurance Company: _____ Plan no: _____ Employee ID: _____

Student Name:_____ Birthdate:_____ Sex: M F

Grade:_____ School:_____ Language: _____

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