Religious Education Registration

Family name(s): _____
Address: _____ Home Phone: _____
City/Zip code: _____ School District: _____

Father's Name: _____ Religion: _____
Address: _____ Cell Phone: _____

Mother's **Maiden** Name: _____ Religion: _____
Address: _____ Cell Phone: _____

Emerg Contact 1: _____ Phone: _____
Emerg Contact 2: _____ Phone: _____

Is your family currently registered with St. Francis Xavier Church? Yes: _____ No: _____

Sacraments – Please include approximate date and church where Sacrament was received.

Children's name	DOB	Baptism **DATE/ CHURCH**	First Eucharist **DATE/ CHURCH**	Confirmation **DATE/ CHURCH**

Amount paid/ CK #: _____Date: _____
Amount paid/ CK #: _____Date: _____
Amount paid/ CK #: _____Date: _____
Amount paid/ CK #: _____Date: _____

Reviewed by: _____ Permanent record completed by/date: _____

Health History & Medical Release for Parish Activities

Child's Name_____

Family Doctor: _____Telephone: _____

Immunizations including:
Tetanus, Measles, Mumps, Polio, Chicken Pox, Rubella, TB, Hepatitis

Up to date? YES_____ NO_____

Special information: (please check all that apply)
Fainting__ Dizziness__ Blackouts__ Asthma__ Seizures__

Kidney problems__ Frequent nose bleeds__ Frequent colds__ Diabetes__

Severe Headaches__ Severe homesickness__ Behavioral Problems__

Additional information regarding health issues: _____

_____

Allergic reactions: (please list all known allergies)

Physical\Mental limitations: (indicate any other medical or emotional problems pertinent to your child)

Current medications: (Unless pre-authorized, medication should be administered by parent/caregiver prior to arrival at St. Francis Xavier)

PERMISSION FOR EMERGENCY TREATMENT:

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

Signature of Guardian: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Family insurance provider: _____

NOTARY SIGNATURE: _____ {Notary Seal}