

2011-2012 **Parish School of Religion [PSR] Registration** Reguistracion para el 2011-2012 **Programa de Educacion Reliquiosa Parroquia [PSR]**

CHECK WHICH DAY YOUR CHILDREN WILL ATTEND [MARQUE CUAL DIA SU HIJO[A] PUEDE ATENDER]:

Sunday Morning [Domingo por la manana] 10:05-10:55 am **OR** Wednesday Night [Miercoles por la tarde] 5:45-6:45pm

Registration Fee [Costo de registracion]: \$25.00 per child [por niño] **Family Limit [Limite por Familia]:** \$50.00
For Children participating in a Sacrament [por Sacramento]: \$10.00 per child [por niño]



Family Email [Familia Correo Electronico]:

CHILDREN [NINOS]	1	2	3	4
Names [Nombres]				
Grade Entering [Grado escolar]				
Date of Birth [Fecha de Nacimiento]				
School Attending [Nombre de la Escuela]				
Date of Baptism [Fecha de Bautismo]				
Church of Baptism [Iglesia de Bautismo]				
Date of 1st Communion [Fecha de Primer Com]				
Church of 1st Communion [Iglesia de Primera Com]				
Date of Confirmation [Fecha de Confirmacion]				
Church of Confirmation [Iglesia de Confirmacion]				

Children live with [El nino vive con]: ___ Both Parents [Sus Papas] ___ Mother [Mama] ___ Father [Papa] ___ Other [Otros] _____

PARENTS [PADRES]	Mother [Madre]	Father [Padre]
Names [Nombres]		
Address [Direccion]		
City/State/Zip [Ciudad/Estado/CP]		
Home Phone [Telefono de la Casa]		
Work Phone [Telefono del Trabajo]		
Cell Phone [Celular]		
Email [Correo electronico]		
Religion of Parent [Religion de los Papas]		
Church where registered [Iglesia a que pertenecen]		
	___ Married [Casado] ___ Single [Soltero] ___ Remarried [Buelto a Casar] ___ Divorced [Divorsiado] ___ Deceased [Finado]	___ Married [Casado] ___ Single [Soltero] ___ Remarried [Buelto a Casar] ___ Divorced [Divorsiado] ___ Deceased [Finado]

Office Use: Check #: _____ **Amount Paid: \$** _____ **Date:** _____



**2011-2021 St. Paul Parish
PARISH SCHOOL OF RELIGION [PSR]
EMERGENCY MEDICAL AUTHORIZATION/PERMISSION FORM**

Only one medical form needed for all children.

Name[s] of Child[ren]: _____

Parent Name: _____

Purpose – to enable parents and guardians to authorize the provision of emergency treatment for children whom become ill or injured while under PSR authority, when parents or guardians cannot be reached.

Name of Relative or Childcare Provider FOR EMERGENCY CONTACT:

_____ Relationship _____

Phone _____

TO GRANT CONSENT:

I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Phone _____

Dentist: _____ Phone _____

Hospital: _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including **allergies**, medications being taken and any physical impairment to which we and a physician should be alerted:

Special Needs: _____

PERMISSION RELEASE:

Permission for my child's picture to be taken and used in brochures, video, CD/DVDs, websites, etc. for publicity use only.

I grant permission I do NOT grant permission

Date: _____ Signature of Parent/Guardian _____

PLEASE COMPLETE AND RETURN WITH REGISTRATION!