GESU & ST. PIUS X - FAITH FORMATION REGISTRATION FORM

Tuition for the school year will be $70.00 per child. A sacramental fee of $50 is additional for 2nd and 8th graders. Please provide tuition payment with this form.

FAMILY NAME:__________________ PHONE____________ **EMAIL___________________________

MOTHER'S NAME_______________Catholic: yes no (If not, please list denomination)__________________

FATHER'S NAME_______________Catholic: yes no (If not, please list denomination)__________________

ADDRESS:____CITY/STATE/ZIP___________________

SUNDAY MORNING EMERGENCY CONTACT NAME AND PHONE________________________________

NAME OF PARISH YOU BELONG TO____

Please put your e-mail address as we will be communicating reminders and important info via the e-mail address you provide. PRINT CLEARLY!

*Place a check mark next to the appropriate sacrament if completed

INFORMATION	CHILD # 1	CHILD # 2	CHILD # 3	CHILD # 4	CHILD#5
Child's Name (Include last name if different from family name)					
School and *grade* this fall					
Date of Birth					
Age and Gender					
Place of Baptism					
- Reconciliation					
-1st Communion					
Special Needs: Physical, medical, emotional, allergies...					

VOLUNTEERS ALWAYS WANTED:

I am willing to :

_______be a classroom helper ________office __________ sub occasionally

OFFICE USE: Tuition Due_______ Tuition Paid ________ Cash/Ck#__________ Date__________

sacrament Fee (if applicable)paid____________Due___________

*****PLEASE FILL OUT MEDICAL AUTHORIZATION FORM ALSO*****

EMERGENCY MEDICAL AUTHORIZATION FORM

Gesu & St. Pius X Religious Education Program Student Name________________________________
Address________________________________
Age ______________________ Phone____________________

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

RESIDENTIAL PARENT OR GUARDIAN

Mother's name________________________________ phone____________________
Father's name________________________________ phone____________________
Emergency contact__________________________ phone____________________

Name of relative or Childcare Provider

________________________________Relationship____________________
Address________________________________ Phone____________________

TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:
Physician________________________________ Phone____________________
Dentist________________________________ Phone____________________
Medical Specialist__________________________ 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 (1) 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 impairments to which a physician should be alerted:

____
____.

Date______________ Signature of Parent or Guardian________________________________
Address____
____

REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:____

Date__________ Signature of Parent/guardian________________________________
Address and Phone____

____