

# Gesu/St. Pius X Parish CCD Registration

**Grades 1-8  
2023-2024**



**First class day of CCD is Sunday, September 17, 2023.**

**Classes will be held at Gesu School on Sundays from 9:00 a.m. to 9:55 a.m.**

**Registration Fee: \$70 for each child (this covers books, activity materials, etc.)**

Please return this form with registration fee c/o Lisa Baumann to the Parish Office or via the weekly collection by 9/10/23 Lisa Baumann: 419-535-7672 ext. 224 or e-mail:

[LBAUMANN@STPIUSXTOLEDO.ORG](mailto:LBAUMANN@STPIUSXTOLEDO.ORG)

Family Name (*last name*): \_\_\_\_\_

Father's First Name: \_\_\_\_\_

Religion \_\_\_\_\_

Mother's Name (*first name & maiden name*): \_\_\_\_\_

Religion \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Parent cell phone: \_\_\_\_\_

Emergency contact— Name: \_\_\_\_\_

Phone: \_\_\_\_\_

e-mail address: \_\_\_\_\_

*(Please include a family e-mail address for ease of contact and the switch to e-mail format for PSR weekly newsletters)*

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Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Sacrament & Date—Baptism: \_\_\_\_\_ First Communion: \_\_\_\_\_

Special needs (if applicable): \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Sacrament & Date—Baptism: \_\_\_\_\_ First Communion: \_\_\_\_\_

Special needs (if applicable): \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Sacrament & Date—Baptism: \_\_\_\_\_ First Communion: \_\_\_\_\_

Special needs (if applicable): \_\_\_\_\_

**St. Pius X/Gesu CCD**  
Emergency Medical Authorization Form  
2023-2024

Student Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

E-mail \_\_\_\_\_

**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 \_\_\_\_\_

mother's e-mail \_\_\_\_\_

Father's Name \_\_\_\_\_ phone \_\_\_\_\_

father's e-mail \_\_\_\_\_

**Alternate Contact Name** (in case of emergency and unable to contact parents or guardian):

Name of Relative or Childcare provider \_\_\_\_\_

Relationship to child \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_

e-mail \_\_\_\_\_

(Please complete reverse side)

Part I or Part II **MUST** be completed

**Part I: To Grant Consent**

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

Physician \_\_\_\_\_ phone  
\_\_\_\_\_

Dentist \_\_\_\_\_ phone  
\_\_\_\_\_

Preferred hospital  
\_\_\_\_\_

Hospital Emergency Room 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 the 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(s) to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date  
\_\_\_\_\_

**Part II: 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian  
\_\_\_\_\_

Date \_\_\_\_\_