

Sacred Heart Parish

CCD REGISTRATION AND EMERGENCY MEDICAL AUTHORIZATION

Due in the Parish Office by July 15

School year: 20____ - 20____ + Grade: _____ + Church: Sacred Heart _____ - Saint George _____

Student's Name: First _____ Middle _____ Last _____

Birth: Month _____ Day _____ year _____ Place of Birth _____

Address: Street _____ Town _____ zip _____

Telephone _____ e-mail _____

Father's name _____ Religion _____

Mother's name _____ Religion _____

For a child going into first grade or new to the program, please check one:

A copy of his/her baptismal certificate is attached _____

I am registering on line. I am sending a copy of the baptismal certificate to the parish office _____

My child was baptized at Sacred Heart Parish; I understand that I will not need to send a copy _____

| | | | |
|-----------------------|-----------------|-----------|----------|
| Student Reception of: | Baptism | yes _____ | No _____ |
| | First Penance | yes _____ | No _____ |
| | First Eucharist | yes _____ | No _____ |
| | Confirmation | yes _____ | No _____ |

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Emergency Medical Authorization

Mother's or guardian's name _____

Where Employed _____ Home / Cell Phone _____

Father's or guardian's name _____

Where Employed _____ Home / Cell Phone _____

IF ABOVE PARENTS/GUARDIANS CANNOT BE REACHED, PLEASE CALL:

(A) First Contact's Name _____

Address _____

Work Phone _____ Home & Cell Phone _____ Relationship _____

(B) Second Contact's Name _____

Address _____

Work Phone _____ Home & Cell Phone _____ Relationship _____

In case of accident or serious illness, I request the parish to contact me or my designate. If this cannot be done, I authorize the parish to call the physician or dentist listed on this sheet, and to follow his/her instructions. If the physician or dentist named cannot be reached the parish may seek medical services that seem necessary. I realize the parish does not assume responsibility for the payment of medical expenses.

Signature of parent or guardian _____ Date _____

In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or physician permission to treat my son/daughter as necessary.

Signature of parent or guardian _____ Date _____

Allergies _____

Medical problems _____

Taking medication Yes _____ No _____

If yes, Type _____ Reason _____

(Medication will be administered at parish only according to current parish policies)

Physician/Clinic _____ Phone _____

Dentist _____ Phone _____

Hospital Preference _____ Phone _____

OR: I do NOT give my consent _____

The cost of books & supplies per family is \$25.00. Please place that amount in an envelope marked with your name & "CCD" and place it in the collection basket.

Signature of Parent or Guardian _____ Date _____

(Revised 5/02/11)