Holy Family
Parish School of Religion

7367 York Rd. Parma, OH 44130
440-842-6658

Student Registration Form
School Year: 2016 – 2017
Grades: K - 8
Register by: 08/31/16

Office Use:
PSR GR: _____
Room: _____
Teacher: _____

*** NEW FAMILIES/NEW STUDENTS ONLY ***

FAMILY INFORMATION: (Please complete a separate form for each child you are registering – BOTH SIDES)

Child's Name: _____ □ Male □ Female
(Last) (First) (Middle Initial)

Address: _____
(Street Address) (City) (Zip Code)

Home Phone: _____ Date of Birth: _____/_____/_____

Public School Child Attends: _____ Grade: _____

Father's Name: _____ Religion: _____
(Last) (First)

Cell Phone: _____ Email: _____

Mother's Name: _____ Religion: _____
(Last) (First)

Cell Phone: _____ Email: _____

SACRAMENTAL INFORMATION:

If you are registering a First Grader or New Student, please provide a copy of their Baptismal Certificate with this registration. Thank you.

Baptism: _____
(Date) (Church) (City & State)

First Communion: _____
(Date) (Church) (City & State)

Confirmation: _____
(Date) (Church) (City & State)

Are you a registered member of Holy Family Parish? Yes _____ No _____

If no, with what Parish are you currently registered? _____
(Name) (City)

PSR INFORMATION & FEES:

- Classes are held on **Tuesday evenings from 6:45pm – 8:00pm** in the Holy Family School Building.
- **Grades 2 & 8** have an ADDITIONAL Sacramental Fee. **The Registration fee & Sacramental fee must be paid.**
- Fees cover cost of books, materials, mailings, etc.
- **Payment must accompany form or contact office to arrange a payment schedule.**

Registration Fee: $50 per child ($120 max per family)

Sacramental Preparation Fees: **(IN ADDITION to the Registration Fee above)**
$25.00 First Communion – Grade 2
$35.00 Confirmation – Grade 8

(Office Use Only:
Date: _____ **Amount Paid:** _____ **Cash:** _____ **Check Nbr:** _____

HOLY FAMILY PARISH SCHOOL OF RELIGION
EMERGENCY MEDICAL AUTHORIZATION

_____
(Child's Name)

COMPLETE EITHER PART I OR II BELOW

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact a parent/guardian have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the designated preferred physician or dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to the preferred hospital or any hospital reasonably accessible.

Emergency Contact: _____ _____
(Name) (Phone Number)

Preferred Physician: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Medical Specialist (if applicable: _____ Phone: _____

Preferred Hospital _____ Phone: _____
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, PHYSICAL IMPAIRMENTS, LEARNING IMPAIRMENTS (ADD/ADHD) THAT WE OR A PHYSICIAN SHOULD KNOW:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

PART II: REFUSAL TO CONSENT (DO NOT COMPLETE IF YOU HAVE SIGNED PART I)

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:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____