St. Teresa of Avila - Parish School of Religion
2018/2019 Student Registration

Grade _____

Student's Full Name: _____ Sex: _____
(First) (Middle) (Last)

Date of Birth: _____ **Day School:** _____

Home Phone: _____ **Cell #**:_____

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

E-Mail Address: _____

Health or learning issues of which we should be aware
(ADHD, Learning Disability, Epilepsy, Diabetes, Allergies, Etc)? _____

_____

Emergency Contact _____ Phone _____ Relationship_____

Mother's full name: _____
(First) (Middle) (Last)

Religion: _____ Marital Status: _____

Father's full name: _____
(First) (Middle) (Last)

Religion: _____ Marital Status: _____

Are parents married to each other? _____

Legal Guardian(s) if other than parents: _____

Guardian's relationship with Student: _____

Sacramental Records (fill in those that apply)

	Church	City, State	Date
Baptism	_____	_____	____/____/_____
1st Eucharist	_____	_____	____/____/_____
Confirmation	_____	_____	____/____/_____

If your child will be attending First Communion or Confirmation classes (and they were not baptized at St. Teresa) please provide a copy of their Baptismal record. Sacramental registration forms will be sent home the second week of class in 2nd and 8th grades. Baptisms are arranged through the **Parish Office 440-934-4227.**

(Fees: $45 registration fee per child with a $115 cap per family. Please make checks payable to "St. Teresa of Avila")

For Office Use

Paid: _____ Date: _____/_____/_____ Check No. _____

Emergency Medical Authorization

Student <u>will not</u> be admitted to class until this form is signed and returned

Students Full Name: _____
(First) (Middle) (Last)

Doctor: _____ Phone: _____

Hospital: _____

Part I: To grant consent
In the event reasonable attempts to contact me (or the child's other parent) at the phone numbers listed with the religious education office have been unsuccessful, I hereby give me consent for (1) the administration of any treatment deemed necessary by the doctor listed above or the dentist listed above, or in the event the designated preferred practitioner is not available, by another licensed physician and/or dentist; (2) the transfer of the child to the preferred hospital listed above or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists concurring in the necessity for such surgery are obtained before the surgery is performed.

_____ _____
Date Signature of parent/guardian

Do not complete this part if you completed part I

Part II: Refusal to consent
I do **<u>NOT</u>** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the religious education office to take no action or to:

_____ _____
Date Signature of parent/guardian

PSR begins Tuesday, September 11, 2018
at 6:00 p.m. in assigned classrooms in Avila Hall
PSR Class Calendars will be distributed at the time of registration.