

**For Office Use**

Family Name: \_\_\_\_\_

School Year: \_\_\_\_\_

Fee: \_\_\_\_\_ Check #: \_\_\_\_\_

## Our Lady of Charity Parish Religious Education Program Summer Registration Form – 2016

*Complete Form. Print clearly. FOR FIRST TIME REGISTRATIONS, PLEASE BRING AN ORIGINAL AND ONE COPY OF EACH CHILD'S BAPTISMAL CERTIFICATE.*

Child's Full Name (First, Middle, & Last)	Sex M/F	Date of Birth	PREP Level <i>For this yr</i>	Name of Day School	Baptism Date & Parish	1 <sup>st</sup> Penance Date	1 <sup>st</sup> Holy Communion Date

Father's Name: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Catholic –  yes  no E-mail \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Catholic –  yes  no E-mail \_\_\_\_\_

Family Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Family Address: \_\_\_\_\_  

Street
City
Zip Code

**IS THERE A CUSTODY ORDER IN PLACE?**  yes  no (If yes, please provide a complete copy of the latest court order.)

Name of step-parent \_\_\_\_\_

Are you a registered member of OLC Parish?  yes  no (If no, please call the Parish Office to make an appt. with Fr. Izzo)

## Our Lady of Charity Parish Religious Education Program Summer Registration Form – 2016

Family Name:

I give permission for my child's name/picture to the parish name website, bulletin boards, newspaper articles in relation to events that happen in the parish. Signature \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:** If we are unable to reach you, whom should we contact?

Name: \_\_\_\_\_ (Cell) \_\_\_\_\_ Phone Number (home) \_\_\_\_\_

**CONSENT FOR MEDICAL CARE:**

I give permission that, in my absence, my children whose names appear on this registration form, may receive emergency medical care for injuries and all situations that should occur while participating in the Religious Education Program programs and activities at **Our Lady of Charity Parish**

Signed (Parent/Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL/LEARNING DATA**

If any of the following apply to your child, please list his/her name and give details in the appropriate spaces.

Child's Name	Medical Conditions/Allergies	Prescribed Medications	Disability* / Learning Support Services	Individualized Education Program <b>IEP</b>
				<input type="checkbox"/> YES
				<input type="checkbox"/> NO
				<input type="checkbox"/> YES
				<input type="checkbox"/> NO
				<input type="checkbox"/> YES
				<input type="checkbox"/> NO

Is there other information about your child that should be communicated?

\_\_\_\_\_

\_\_\_\_\_