PLEASE INCLUDE $10.00 PER FAMILY REGISTRATION FEE

FAMILY ENROLLMENT

K-6 GRADE RELIGIOUS EDUCATION PROGRAM - SACRED HEART PARISH

Family Name_____ Date_____

Address_____ City_____

Phone_____ Cell#_____ Email_____

Father's Name_____ Religion_____

Mother's Name_____ Religion_____
First Maiden

Children live with: Parents____Mother____Father____Other (Specify)_____

Parish where registered:_____

In case of emergency, if parents cannot be reached, call:_____

CHILDREN			BIRTHDAY			GRADE
First	Middle	Last	Mo.	Day	Yr.	2019-2020

Any physical, emotional or learning challenges we should be aware of:

ALL FAMILIES:
Please check the box for each sacrament your child has received.

NAME	Baptism	Confirmation	Eucharist	Penance

NEW STUDENTS:

____Has never had any formal religious instruction ____Has had formal religious education instruction

Transferred from_____

(OVER, PLEASE)

SACRED HEART PARISH 2019-2020 AUTHORIZATION FORM

Please fill in the appropriate information and check the appropriate boxes
Pint, then sign the form

SACRED HEART PARISH will not photograph, videotape and/or voicetape individuals in its programs without consent. This form allows you to give permission for your child/children to be photographed, videotaped and/or voicetaped by parish personnel and/or area news reporters. Photographs, videotapes and/or voicetapes, when consented to, will only be used for the purposes you specify below. (Please check appropriate ☐.)

☐ I,_____, hereby give permission for the personnel of Sacred Heart Parish to photograph, videotape and/or voicetape my child/children (or allow area news reporters to do the same.)

☐ I,_____,hereby **DO NOT** give permission for the personnel of Sacred Heart Parish to photograph, videotape and/or voicetape my child/children (or allow area news reporters to do the same.)

This consent must be re-examined and signed each year.

Student Name(s) _____

_____

_____

MEDICAL TREATMENT AUTHORIZATION (please check box)

☐ As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition, which in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

_____
Parent's Printed Name

_____
Parent Signature Date