St. Rose Rel. Ed Faith Formation

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(916)783-5211 Ext. 7010

Registration 2017-18

Fees: $75 for 1st Child & $35 for ea. additional child

**Church Subsidy available upon request

Date of Registration:			
Registration Amt Paid:		Bal. Due	
Form of pymt:	Check #:	Cash:	
Received by:			

Returning Student ___ or New Student ___ or Transferring from: _____

Are you registered at St. Rose Parish? _____

Student Name_____Male/Female:_____

Birth Date: _____ Grade: _____ Home Phone: _____

Email_____

Address: _____

City: _____ Zip _____

Father: _____ Phone Number: _____

Mother: _____ Phone Number: _____

Sacraments Received (name all completed)_____

****Please note that Sacraments require <u>two consecutive</u> years of preparation**

Circle Class Day Choice:

(for 4yrs through 5th & 6th Grade Sunday's ONLY)

Sunday's 10:30 am – 11:30 am **OR** **Wednesdays from 4:00 pm – 5:00 pm**

Starting: Sunday Oct. 8, 2017 **Starting: Wed. Oct. 11, 2017**

through Sun. March 25, 2018 **through Wed. March 21, 2018**

Confirmation Students: Year 1 & 2 please Register with Beckee Szumski. (7th and Up)

Class Assignments will be posted the first day of class!

Please complete the back ------->

Thank You~

Saint Rose Religious Education

Emergency Form

Student Name: _____ Birth date: _____

Address: _____ Telephone: _____

Parent cell or emergency contact number: _____

If I/we cannot be reached you have my/out permission to contact either of the following persons:

1. Name: _____ Number: _____ Relationship _____

2. Name: _____ Number: _____ Relationship _____

Name of Family Physician: _____Telephone: _____

Family Health Plan Carrier: _____ Policy No: _____

I understand that the Religious Education program does not assume responsibly for payment of a physician. If our physician cannot be reached, a parish official may choose a physician: Yes ___/No___

Authorization of Consent for Treatment of a Minor

In the event of a serious emergency and none of the person listed in this form can be contacted, I authorize Religious Education officials to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent for any X-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by and rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at the certified hospital.

I hereby agree to bear all costs incurred as a result to the foregoing.

_____

Parent's Name (please print)

_____ _____

Parent's signature Date

My child listed above is **ALLERGIC** to: _____

My child listed above has been diagnosed with the following Medical Condition(s):

_____

Anything additional you would like us to know to help teach your child (temperament/behaviors)

_____

** I choose not to sign the above statement. In the event of an accident or emergency please:

_____

_____ _____ _____

Parent's Name (please print) Parent's signature Date