



St. Brigid Catholic Church
Faith Formation Registration Form 2010-2011
 Grade School and Youth: Pre-K – Grade 12

Are you a **registered parishioner**? Yes _____ No _____

Please circle below the class day & time you wish your child to attend:

Sunday @ 9:15 a	Pre-K	K	1	2	3	4	5	6	7	---	---	---	---	---
Sunday @ 1:45 p	---	K	1	2	3	4	5	6	7	8	9	10	11	12
Tuesday @ 6:30 p	Pre-K	K	1	2	3	4	5	6	7	8	9	10	11	12

Fee Information: **One Child - \$50** **Two Children - \$65** **Three or more children - \$80**

Payment Information: For office use only

Payment in **FULL** Rec'd date: _____ Amount: \$ _____ Cash Check # _____ Staff Initials: _____

Amount of 1/2 Payment: \$ _____ Rec'd date: _____ Cash Check # _____ Staff Initials: _____

Remainder due in 60 days Due Date of payment: _____ Rec'd date: _____ Cash Check # _____
 Staff Initials: _____

Please complete all information:

Student's Full Name: _____ (F) _____ (M) _____
 (First) (Middle Initial) (Last)

Date of Birth: _____ Place of Birth: _____

Information needed for sacramental records:

Date of Baptism: _____ Place of Baptism: _____

First Reconciliation (Confession/Penance) Yes ___ No ___ First Communion (Eucharist) Yes ___ No ___

Confirmation Yes ___ No ___

Family Information:

Head of Household: _____ Relationship to child: _____
 (First) (M.I.) (Last)

Spouse: _____ Relationship to child: _____
 (First) (M.I.) (Last)

Address: _____ Zip: _____

Phone # (H) _____ (W) _____ (C) _____

If child is not living with one or both parents:

Guardian Name: _____ Relationship: _____

Medical Release Form

In case of an emergency, please contact:

We will contact a parent first; however, **if parent is not available**, please list a person below **other than a parent** who can be contacted on an emergency:

Name: _____ Phone #: _____

Emergency Medical Treatment: In the event of an emergency, I hereby grant permission to transport my child to a hospital for emergency medical treatment: _____ **Yes** _____ **No**

I wish to be advised **prior** to any further treatment by the hospital or doctor: _____ **Yes** _____ **No**

Family Doctor: _____ Phone Number: _____

Insurance Carrier: _____ Policy Number: _____

My child is allergic to the following (medications, foods, plants, insects, etc.): _____

My child's immunizations are current and up to date: _____ **Yes** _____ **No**

My child's last tetanus/diphtheria immunizations are within the last 5 years: _____ **Yes** _____ **No**

My child has the following medical or physical limitations: _____

Will your child have any special needs we should know about? _____

Please Initial:

_____ I give permission for my child to be photographed. _____ I do not want my child photographed.

I verify that all the information I have provided on these two pages is true and accurate to the best of my knowledge.

Signature of Parent or Guardian

Date