St. Aloysius Gonzaga/St. Jude Parish School of Religion Registration Form for the 2018/19 School Year (*Complete both sides of the Form*)

Student Information (*Complete all information*)

Student's Baptismal Name: _____
Last First Middle

Nickname: _____ Birth Date ____/____/____ Circle one: Male Female

Student's Address: _____
Street Address

_____
City State Zip Code

Student lives with (*Circle one*): **Both Parents** **Mother** **Father** **Other Guardian**

Parish where family is registered: _____
Name of Church

Name of Public School now attending: _____ Grade Level: _____

Registering for PSR Grade: _____ Circle all PSR Grades your child has completed: 1 2 3 4 5 6 7 8

Please list any information regarding your child that a teacher should know (e.g. medical alert, special needs, etc.)

_____

_____

New students to the PSR program

*A copy of the Baptismal Certificate is required for all **NEW** students registering for the PSR program.*

Please list the dates and churches where the student celebrated the following sacraments (complete all that apply).

Baptism: _____ Date ____/____/____
Name of Church

_____
City State Zip code

First Communion: _____ Date____/____/____
Name of Church

Confirmation: _____Date____/____/____
Name of Church

Contact Information (*Complete all that apply*.)

Mother's contact information _____
Mother's Name Home Phone

_____
Work Phone Cell Phone **E-mail address**

Address (if different than student's): _____ Stepfather _____

Father's contact information _____
Father's Name Home Phone

_____
Work Phone Cell Phone **E-mail address**

Address (if different than student's): _____ Stepmother _____

Guardian's contact information (if applicable): _____
Guardian's Name Home Phone

_____
Work Phone Cell Phone **E-mail address**

Parents Pledge

As parents/guardians, we recognize and accept our role as the primary religious educators of our children. We pledge to support the PSR program and its catechists regarding attendance, participation, discipline, and homework assignments. We will do our part to encourage our child's spiritual growth by regularly attending mass and receiving the sacraments.

Signature: (*Required*) _____

Fees: PreSchool-K $40. Grades 1-8 $70 for 1 child, $90 for 2 children and $120 for 3 or more. **Make checks payable to St. Jude Parish. Return all forms and payment to the Parish office by August 1**

No child will be denied a religious education due to a lack of payment.
If you need tuition assistance, please contact the parish office.

Fee Discounts and waivers are available for parents who volunteer in the PSR program.

____I am interested in volunteering as a Catechist, a Classroom Assistant, or Hall Monitor during PSR class times. Name: _____ Phone # _____

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The following release form will enable my child to participate in all scheduled PSR and sacramental preparation activities as identified in the PSR Handbook and as amended in the PSR newsletter.

ARCHDIOCESE OF CINCINNATI PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or guardian of (name of student) _____ (the "child"), give permission for my child to participate in the activity described above and release from all liability and indemnify the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity.

2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

3a. I appoint the Archbishop or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the child.

(ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.

4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

****Parent Signature**: _____ Date____/____/____**

****Printed Name**: _____**

Emergency Medical Preferences (**Required information)

****Doctor's Name: _____ Phone: _____**

****Dentist's Name: _____ Phone: _____**

****Medical Specialist: _____ Phone: _____**

****Local Hospital: _____ Phone: _____**

Children's Hospital Emergency Room # is 636-4293

****Facts concerning the child's medical history including chronic conditions, allergies, medications being taken and any physical impairments to which a physician should be alerted: _____**

_____

_____

****Emergency Contact if mother, father, or guardian cannot be reached: _____**

Last Name First Name

_____

Relationship to student Evening phone number

****All required information must be completed on the Registration Form !**