

RELIGIOUS EDUCATION

ST. AGNES/ST. CECILIA

Mother's name: _____ Mom's cell #: _____ Mom's email: _____

Dad's name: _____ Dad's cell #: _____ Dad's email: _____

Home address: _____

Student :

Last name: _____ First name: _____

Date of birth: _____ Grade this fall: _____

List any medical conditions, food allergies or academic challenges:

IMPORTANT: Your family must be registered with the parish

Photo permission: I release St. Agnes/St. Cecilia Parish of any and all liability and give permission to have pictures of my family members on the parish web site and bulletin.

Yes [] No []

EMERGENCY CONTACT: Name: _____ Phone #: _____

(other than parent) relationship to child: _____

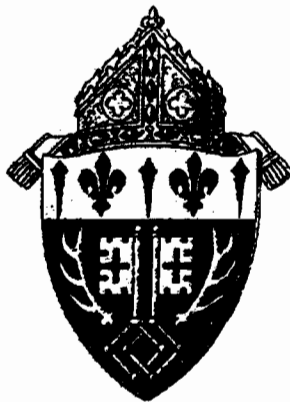
Parent signature: _____ Date: _____

SACRAMENTS:

Baptism: yes __ no __ Date _____ Location _____

Reconciliation: yes __ no __ Date _____ Location _____

First Communion: yes __ no __ Date _____ Location _____



EMERGENCY MEDICAL TREATMENT RELEASE FORM

(Recommended Form)

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger the life of the student, cause a disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor _____ Relationship to you _____

Reason for which release is intended _____

Address of Minor _____ Phone _____

Emergency Phone _____

Family Physician _____ Phone _____

Address _____ City _____

List allergies, medication, contacts, or other pertinent information:

Health Insurance Data:

Company _____ Policy _____

Group _____ Contract _____

This Release Form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date _____ Signed _____

(Parent or Guardian)