OUR LADY OF THE ANGELS PARISH SCHOOL OF RELIGION
REGISTRATION FORM FOR 2017 - 2018

Student's Name: ___________,_____________________________ **Age:** ______ **Grade:** ______
Last First Middle in 9/17

Place of Birth: ____________________________________ **Birthday:** ___________________
City State Month/ Day/ Year

Address: ____ **Phone: (H)** _________________
Number Street City Zip

Mother's Name: __________________________________ **Religion:** ___________________
First Last (Maiden)

Mother's Cell Number: __________________ **Mother's Work Number:** __________________

Father's Name: __________________________________ **Religion:** ___________________
First Last

Father's Cell Number: __________________ **Father's Work Number:** __________________

Guardian's Name (if not parent)**:** ______________________________ **Religion:** ____________
First Last

Parent's Email Address: ____

Public School Attending: ____________________________ **Previous PSR Classes Y N**

Parish registered with: _________________________________ **City:** ____________________

PLEASE FILL OUT ALL OF THIS FORM COMPLETELY
NOTE: A copy of Baptism certificate is REQUIRED for all students in a Sacramental preparation class- First Reconciliation/First Eucharist (Grade 2) or Confirmation (Grade 8)

Baptism: ____
Month/ Day/ Year Church City State

First Eucharist: ____
Month/ Day/ Year Church City State

______ **My child has not yet received his/her sacraments.**

I am interested in having my child receive his/her sacraments. Y N

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Payment rates are the following: **One child - $30 / Two children - $60 / Three Children - $90**

More children? Please contact the DRE, Miss Kathy Stary, at (216)251-2332 or kstary@olangels.org. If there is any problem, do make contact as it is important that the children have consistent religious education as well as thorough preparation for the sacraments.

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OFFICE USE ONLY

Date of payment: ______________________ Check # _______________ Cash ____________

If paying at a later time, indicate that date here: _____________________________________

EMERGENCY MEDICAL AUTHORIZATION

Child's Name: _____ Age: _____ Soc. Security # _____

Food Allergies: _____

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents/guardians can not be reached.

PART I or PART II must be completed.

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me by phone at _____ or _____(other parent/guardian) by phone at _____ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____(preferred doctor) or Dr. _____(preferred dentist) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____(preferred hospital) or any reasonably accessible hospital.

This authorization does not cover any major surgery unless the medical opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

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

_____
_____
_____
_____

Date: _____ Parent signature: _____ Address: _____

(Do NOT complete PART II if you have completed PART I)

PART II (REFUSAL TO CONSENT)

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take NO ACTION or to:

_____
_____

Date: _____ Parent signature: _____ Address: _____

This is an important precautionary measure that is hoped will never need to used.