

Saint Paschal Baylon Parish School of Religion (PSR) Registration Form 2019-2020

Office Use Only: Ch#: Paid: Date:
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<u>PSR Tuition</u>		
1 child - \$95	2 children - \$170	3+ children - \$240
Note: Two years of sacramental preparation is required. Checks can be made payable to Saint Paschal Baylon		

As this serves as a registration form, an emergency medical form, and a media release form, please write legibly. No registration will be processed unless both sides are complete.

Family Information:

Family's Last Name:	Today's Date:	PSR meets Mondays from 6:30-7:30pm for grades K-8.
Address:	City:	Zip:
Home Phone:	Are parents registered at Saint Paschal Baylon (SPB) Parish? CIRCLE: Yes /No	
Mother's Name:	Mother's Cell:	Mother's Religion:
Father's Name:	Father's Cell:	Father's Religion:
Required: Email address (Email is our primary form of communication. List all addresses at which you wish to receive PSR updates.)		



Student Registration Information:

Student's First & Last Names	M/F	DOB (m/d/y)	Grade for '19-'20 school year	School Attending '19-'20	Sacraments Received (Check all that apply)				Did this child attend SPB for PSR '18-'19?	Any Allergies, Medications, Learning Disabilities, Behavior Problems, Special Needs
					Bapt.	Rec.	Euch.	Conf.		
1.									Circle: Yes / No	
2.									Yes / No	
3.									Yes / No	
4.									Yes / No	
5.									Yes / No	

****IMPORTANT Registration Information is Needed on the Back of This FORM.****
Please make sure to sign the back of this form in BOTH signature areas.

Child/Children Home Life: (Please Circle)

- A. Two Biological Parent Family
- B. Single Parent and child(ren) live with
 - a. Father
 - b. Mother
 - c. Stepfather
 - d. Stepmother
- C. Father is deceased
- D. Mother is deceased

Are parents Divorced? Yes / No

If parents are divorced, is there a court order which limits/prohibits non-custodial parent contact? Yes / No

If yes is circled, parent must contact the principal and provide legal documentation.

Other: _____

Medical Emergency Information – Parents are called FIRST in an emergency. **MUST complete all columns.**

Child's Name	Doctor/Phone #	Dentist/Phone #	Hospital/Phone #
1.			
2.			
3.			
4.			
5.			

Emergency Contacts: List the **NON-PARENTAL** persons who will care for your child in case of emergency if **parent cannot be reached**.

List contacts in the order in which you prefer them to be called. **Must list ALL THREE contacts.** If less than 3 contacts are listed, parents understand that SPB PSR is not at fault if we cannot reach contacts listed.

Name of Non-Parental Emergency Contact	Phone #	Relationship to Child(ren) [can't be parent]
1.		
2.		
3.		

If we are unable to contact parents, emergency ambulance will be utilized to transfer the child to the preferred hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Please sign permission for critical emergency treatment for your child(ren) to be treated. Granting consent and signing this states that you will accept full financial responsibility for charges connected with the use of an ambulance and for charges connected with care at the hospital.



Sign below if you grant consent for emergency medical treatment of your child(ren).

Yes, I do grant consent for emergency medical treatment of my child(ren). **Parent/Legal Guardian Signature:** _____ **Date:** _____



Sign below if we may take pictures/video of your child(ren) for PSR purposes.

Yes, PSR may take photos/videos of my child(ren) for PSR purposes. **Parent/Legal Guardian Signature:** _____ **Date:** _____

Please include any additional pertinent information here: (Please include special arrangements for pick-up or carpool & other requests. We cannot guarantee any requests after 8/1.)

