Saint Augustine Parish Religion Program
Registration 2017-18

STUDENT'S NAME ______________________ Phone number ____________
Last First

Address ____________________________________ E-mail ____________
City Zip

Birth date _________________ School _________________ Grade ________

Student's place of birth __________________________ High School Graduation Year ________

FATHER'S NAME ___________________________ Phone number ____________
Address (if different from child's) ____________________ E-mail _________________

MOTHER'S NAME _________________________ Phone number ___________
Address (if different from child's) ____________________ E-mail ________________
Mother's maiden name _____________________________

Parent's Marital Status: married separated divorced* remarried widowed
*Who is the custodial parent? ______ Will parent visitation affect PRP classes? _____

Is father a member of St. Augustine Parish? ______
Is mother a member of St. Augustine Parish? ______

CHILD'S SACRAMENT HISTORY

Baptism was received at ______________________ (parish)________________(city) ________(date)

Godparent names ____

First Communion was received at __________________ (parish)________________(city) ________(date)

Confirmation was received at ____________________(parish)__________________(city) ________(date)

FEES

Registration

1st to 8th grade (per child):	$50.00	$_________
Family Plan (3 or more children in same family):	$115.00 total	$_________

Sacrament

Reconciliation/First Communion (grade 2):	$35.00	$_________
Confirmation (grade 8):	$35.00	$_________

TOTAL DUE: $____________

OFFICE USE ONLY: Date paid: _________ Cash: ________ Check number: _________

Medical Form: ________ Received by: _______________

Rev. 8/1/17

EMERGENCY MEDICAL AUTHORIZATION FORM
2017-18

Student's Name_______________________________________DOB____________Grade___________

Address____City_________________________

Purpose - to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under parish authority, when parents or guardians cannot be reached.

If there is an emergency, make an attempt to contact me:

Name____Relationship___________________

Phone_________________Cell Phone______________________Other (Phone)_________________

If I cannot be reached, please contact:

Name____Relationship___________________

Phone_________________Cell Phone______________________Other (Phone)_________________

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GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be notified:

Physician____Phone_______________________

Dentist____Phone_______________________

Local Hospital____Phone_______________________

Insurance Company______________________Policy Number________________Phone___________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by able named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of my child to 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.

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

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Signature of Parent/Guardian____Date__________________________

Address____City______________________________________

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REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the parish authorities to take the following action:

____

Signature of Parent/Guardian____Date__________________________

Address_________________________________City_______________________Phone___________________________