RELIGIOUS EDUCATION PROGRAM
Immaculate Conception B.V.M. Roman Catholic Church
106 Carlisle Street, New Oxford, Pennsylvania 17350-1102
2018-2019

Child's Name _____ Grade _____
First Last

Date of Birth _____ Place of Birth _____
Month Day Year

Address _____ Phone # _____

E-mail _____ Cell # _____

Father's Full Name _____ Religion _____

Mother's Full Name _____ Religion _____
(Include Maiden Name)

Please list any special needs your child may have that **I** should know about: (ADD/ADHD, Allergies, Asthma, or a Learning Disability of any kind, etc.)

_____

Name of person who **usually** drops off/picks up your child: _____

Name of person to be contacted in case of an emergency:

_____ _____
Name/Relationship to child Phone #

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Sacramental Records: A copy of the child's baptism certificate **must be sent** if your child was **not** baptized at **Immaculate Conception.**

Baptism _____ **Date** _____
Church City State Month Day Year

Emergency Medical Authorization

(Please Print) 4109.2 (A) RE

Student's Name _____ S.S. # _____ Birth Date _____ _____ _____

Address _____ Home Phone _____

Mother's or Guardian's Name _____

Where Employed _____ Telephone # _____

Father's or Guardian's Name _____

Where Employed _____ Telephone # _____

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IF PARENTS OR GUARDIANS CANNOT BE REACHED, PLEASE CALL

((A) First Contact's Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

(B) Second Contact's Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

In case of accident or serious illness, I request the parish to contact me or my designate. If this cannot be done I authorize the parish to call the physician or dentist who are listed on this sheet and follow his/her instructions. If the physician or dentist cannot be reached, the parish may seek medical services that seem necessary. I realize the parish does not assume responsibility for the payment of medical expenses.

Signature of Parent or Guardian _____ Date _____

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In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or physician permission to treat my son/daughter as necessary.

Signed _____ Date _____

Allergies (please list) _____

Medical Issues _____

Taking Medication Yes _____ No _____

If yes, Type _____ Reason _____

(Medication will be administered at parish only according to current parish policies.)

Physician _____ Phone # _____

Dentist _____ Hospital Preference _____ Phone # _____

OR

I do **NOT** give my consent for emergency medical treatment for my child. In the event of illness or injury requiring medical treatment, I wish parish authorities to take no action or to:

_____

Signature of Parent or Guardian _____ Date _____