ST. FRANCIS DE SALES PSR REGISTRATION FORM (GRADES 1-8)
2013-2014

New registration _____

Former parish_____

Fee Paid_____

Child's Name _____Family Name_____

Home Address _____City _____Zip _____ Phone _____

Child's Date of Birth _____

What Public School does your child attend? _____Grade level _____

Which sacraments has your child received?

Baptism YES NO Church _____Date _____

Penance YES NO Church _____Date _____

First Communion YES NO Church _____Date _____

Confirmation YES NO Church _____Date _____

Are you a registered and contributing member of St. Francis de Sales Parish? YES NO

Name of Father: (First) _____(Last)_____Religion _____

Daytime Contact: Phone: _____ Email Address:_____

Name of Mother: (First) _____(Last)_____Maiden_____Religion _____

Daytime Contact: Phone: _____Email Address:_____

Child lives with: ____mother & father _____stepmother & father ____stepfather & mother _____mother _____father ____guardian

GUARDIAN'S NAME _____ (only if not with parents)

Daytime Contact: Phone: _____Email Address:_____

ST. FRANCIS DE SALES PSR EMERGENCY CONSENT FORM

Student Name_____

To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under the authority of the Parish School of Religion when parents/guardians cannot be reached.

____ I give my consent for treatment in the event reasonable attempts to contact me at _____

or other parent or guardian at _____ have been unsuccessful, I hereby give my consent for

the administration of any treatment deemed necessary by _____at_____ or
(preferred doctor name) (doctor phone #)

by_____at_____
(preferred dentist name) (dentist phone #)

or in the event the designated preferred physician or dentist is not available, by another licensed physician or dentist; and the transfer of the child to

_____ or any reasonably accessible hospital.
(preferred hospital)

Please list any medications, health problems or allergies:_____

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

Parent/Guardian Signature:_____ Date:_____

_____I do not give my consent for emergency medical treatment of my child. In the event of illness or emergency treatment required, I wish the

parish/PSR authorities to take the following action: _____

_____

Parent/Guardian Signature:_____Date:_____

Emergency Contact Name:_____Number:_____ Relationship:_____

Emergency Contact Name:_____Number:_____ Relationship:_____