

ST. CLARE PARISH SCHOOL OF RELIGION
REGISTRATION FORM

Student's Name: _____

or
Male Female

First

Last

School Attending: _____ Grade _____

Address: _____ Home Phone: _____

Street Number City Zip

Parent's E-Mail: _____ Parent's Cell: _____

Father's Name _____ Religion _____

Mother's Name _____ Religion _____

First Mother's Maiden Name

Are you a registered member in St. Clare Parish? Yes _____ No _____

I am interested in volunteering, please call me: _____

CHARACTER OF HOME: (Please Circle)

- A. Two Parent Family
B. Single Parent and child is living with... a. Father b. Stepfather
c. Mother d. Stepmother
C. Court Ward/Foster Child
D. Father is deceased
E. Mother is deceased

Guardian (If applicable) _____ Religion _____
Address _____ Phone _____

Are Parents Divorced? _____ Yes _____ No

If parents are divorced, are there any custody restrictions we need to be aware of?
Please note: _____

Emergency Contact _____ Phone _____

Student's Date of Birth _____ Birthplace (City, State) _____

Date of Baptism (please supply a copy of baptism certificate) _____

Church of Baptism _____

Church Address _____
(City) (State) (Zip)

If applicable: Date of First Communion: _____

Church _____ City, State, Zip _____

Please supply a copy of First Communion Certificate at time of initial registration.

Received Sacrament of Reconciliation: Yes _____ No _____

Previous Religious Education (if not registering for Grade 1)

Has your child attended any formal religion classes prior to this registration?

Yes _____ No _____ If yes, which grade level did he/she last complete? _____

Name of Parish _____ Attended: (please circle) Catholic Day School PSR

Medical, physical conditions, special needs or food allergies: _____

May we take pictures/video of your child for PSR purposes? _____ Yes _____ No

Parent/Legal Guardian Signature _____ Date _____

PSR Registration Fee: One Child \$100.00 Two Children \$150 Three or More Children \$200
\$150 per child for those not active, registered or participating members of St. Clare

Make checks payable to St. Clare PSR

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at: () _____ or _____
(phone) (other parent)
at () _____ have been unsuccessful, I hereby give my consent for: (1) The administration
of any treatment deemed necessary by Dr. _____, or Dr. _____ or in the
(Dentist) (Physician)
event the designated preferred practitioner is not available, by another licensed physician or dentist; and
(2) The transfer of the child to: _____ hospital or any hospital reasonably
accessible. This authorization does not cover major surgery unless the medical opinions of two other
licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before surgery
is performed.

Date: _____ Signature of Parent or Guardian: _____

PART II (REFUSAL TO CONSENT)
DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 school authorities to take no action or to:

Date: _____ Signature of Parent or Guardian: _____

**It is also necessary for us to have the doctor's name and phone number. Please include this
information below:**

Doctor: Name: _____ Phone: _____

Dentist: Name: _____ Phone: _____

RE: Privacy Act. It is understood that no student information will be given out without parental consent. However, we
wish to inform you that your name and home phone number will be given to selected adults who will keep the
information confidential and will use it only to inform you of emergency situations. If you have any problem with this
policy, please call me at (440) 449-4242 ext. 119.

I have read the above statement regarding the Privacy of Student Information.

Date: _____ Signature: _____