ST. CLARE PARISH SCHOOL OF RELIGION
REGISTRATION FORM

Student's Name: _____ ☐ or ☐
First Last Male Female

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 Church of Saint Clare 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: _____