



# Holy Savior Catholic Church Parish School of Religious Education Registration

Registration Fees: 1 child \$20 2 or more \$40

## Contact Info

Please Print

Mother \_\_\_\_\_

Cell \_\_\_\_\_

Email \_\_\_\_\_

Father \_\_\_\_\_

Cell \_\_\_\_\_

Email \_\_\_\_\_

Single Married Divorced

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

## MEDICAL RELEASE

*In the event that the undersigned cannot be reached and in the judgment of the Director of Religious Education or other person responsible for the program/group, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my child, I (we) hereby authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.*

\*\*\*\*\* Signature Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## PHOTO PERMISSION

*I give permission for my child's picture to be used for classroom use, Catholic newspaper, Holy Savior Facebook. (please circle) Yes No*

Amount paid: \_\_\_\_\_ Check # \_\_\_\_\_ Cash \_\_\_\_\_ Volunteer Catechist Free \_\_\_\_\_

SEE OTHER SIDE

## Student Info

## Please Print

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

Sacraments Received     Baptism     Penance/Communion     Confirmation

Allergies \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

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Allergies \_\_\_\_\_