CCD Registration Form

St. Rose Religious Education 2022-23

CCD PARTICIPANT INFORMATION (Grades K-8)

Family Last Name(s)____

Address: ______________________________________ City, State, Zip: ____________________

Home Phone (   ) _______________ E-Mail Address. ______________________________________

Father's Name _____________________________________ Father's Cell (   ) _________________

Mother's Name _____________________________________ Mother's Cell (   ) _________________

Mother's Maiden Name _____________________________ Are you all members of St. Rose? Y/N

- For notifications I prefer Text____ Call____ Email_____Phone_____
- Sign me up for Remind 101 CCD alerts: ______

  We use Remind 101 to inform you of closings and other information through text and email
- In case of emergency (and parents/guardians can't be reached) please contact

  ______________________________ Number ________________
- Please list any other information we should know about your child (allergies, educational needs, etc here or another sheet of paper:____
  ____
  ____

Please list ALL children's FULL NAMES, birthdays, and the grades they will be entering for CCD:

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PHOTO PERMISSION:
Do we have permission to include your child(ren)'s picture in parish publications, such as the bulletin of our CCD Facebook page? Yes, you may use my child(ren)'s picture ______ No, you may NOT use my child(ren)'s picture _____

_______________________________________ ______________________________
Signature of Parent/legal guardian Date

TUTION: ONE CHILD = $35……………...TWO CHILDREN = $70…………. THREE OR MORE CHILDREN = $90
Tuition fees cover the costs of books, classroom materials and supplies, and activities costs.

Payment of $______________________ enclosed. (Check number __________ / Cash _______)

For more information, please contact Jeannine Frederick (Director of Religious Education) at 330-545-4341 or at stroseparishdre@gmail.com.

ST. ROSE PARISH (CCD & YM PROGRAMS)
EMERGENCY MEDICAL AUTHORIZATION

Child Name ____ Grade ___________

Address ____

Phone (   ) ________________________________

To enable parents/guardians to authorize the provision of emergency treatment for a child who becomes ill or injured while attending the CCD or YM Program at St. Rose Parish.
CCD & YM Location: St. Rose School, St. Rose Church, Rosetta Hall, and Parish Grounds.

I hereby give my consent for: (1) the administration of any treatment deemed necessary by
Dr. ____ (preferred physician) or
Dr. ____ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to
_________________________________(preferred hospital) or any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. **Every effort will be made to contact the Parent/Guardian first.**

Medical Information: Please check and complete one of the following:

_____ My son/daughter is covered by hospitalization and medical insurance under
Policy # ________________________ Issued by____

_____ My son/daughter does not have medical coverage, and I assume the responsibility for the cost of the hospitalization and medical care for my son/daughter.

Add any other medical information concerning medications, allergies, illness, etc.

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In the event I cannot be contacted, please contact
Name/Phone: ____

PLEASE SIGN ONE OPTION BELOW

____

Signature of Parenti Guardian authorizing care **Date**

I do not consent to the Emergency Medical Authorization for my child.

____

Signature of Parent **Date**

Parent/Guardian Comments:
Please describe below any special medical instructions (include all allergies, allergic reactions to medicines, food allergies) or other special circumstances concerning your child in an emergency situation.

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