CCD Registration Form

St. Rose Religious Education 2023-24

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:

_____

_____

_____

_____

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.
_____
_____

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.

_____
_____
_____
_____