ST. ROSE CHURCH RELIGIOUS EDUCATION

48 EAST MAIN STREET – GIRARD, OH 44420

Parish Office Phone: 330 545-4351

CCD – Grades K-8 Registration Form

Please complete ONE form for each child

Child's FIRST Name:_____ Child's LAST Name:_____

Address: _____ City, State, Zip:_____

Child's Date of Birth: _____ CCD/YM Grade Level Child will be entering: _____

Home Phone: (___)_____ Parent/Legal Guardian E-Mail Address:_____

Father's Name: _____ Father's Cell: (___)_____

Mother's Name: _____ Mother's Cell: (___)_____

Mother's Maiden Name: _____ Are you ALL registered members of St. Rose? Yes or No

- For notifications I prefer: Text____ Call____ Email_____Phone_____
- Sign me up for Remind 101 CCD alerts: Yes or No
  (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:
  _____ Relationship to child: _____ Phone#: (___)_____
- Please list any other information we should know about your child (allergies, educational needs, etc… here or another sheet of paper: _____
  _____
  _____

PHOTO PERMISSION:
Do we have permission to include your child's picture in parish publications, such as the parish bulletin, website and CCD Facebook page?

YES: you may use my child's picture ____ NO: you may NOT use my child'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 _____)

PLEASE COMPLETE THE EMERGENCY MEDICAL AUTHORIZATION ON BACK

ST. ROSE CHURCH RELIGIOUS EDUCATION

Emergency Medical Authorization

Child's FIRST Name: _____ Child's LAST Name: _____ Date of Birth: _____

Address: _____ City, Zip: _____ Grade Level:_____

PARENT/LEGAL GUARDIAN Name and 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 Programs at St. Rose Parish and on Parish and School 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 to the closest hospital.

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 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.

In the event I cannot be contacted, please contact: Name and Phone: _____ (___) _____

Parent/Legal 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.

_____

_____

PLEASE SIGN ONE OPTION BELOW:

YES - I do give consent to the Emergency Medical Authorization for my child.

_____

Signature of Parent/Legal Guardian authorizing care **Date**

NO - I do NOT give consent to the Emergency Medical Authorization for my child.

_____

Signature of Parent/Legal Guardian **Date**