HOLY ROSARY CCD RELIGIOUS EDUCATION 2017-2018

1313 A STREET
ANTIOCH, CA 94509
PHONE: 925-757-9515

PLEASE PRINT CLEARLY ***The information provided below is considered CONFIDENTIAL and is used only for communication purposes by this office.***

FAMILY NAME:_____ Circle One: Mr. & Mrs. Ms. Mr.

ADDRESS: _____ Home Phone: _____

CITY: _____ ZIP: _____ Registered in the Parish: ☐ Yes ☐ No

Primary E-Mail Address _____

PARENTS/GUARDIANS INFORMATION

Name: _____
First Last Maiden Name

Relationship:_____
(Mother, Stepmother, Grandmother, etc.)

Occupation:_____

Bus. Phone: ( ) _____

Cell Phone: ( ) _____

Religion: ☐ *Catholic* Other _____

Name: _____
First Last

Relationship: _____
(Father, Stepfather, Grandfather, etc.)

Occupation: _____

Bus. Phone: ( ) _____

Cell Phone: ( ) _____

Religion: ☐ *Catholic* Other _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Single

Students live with: ☐ Both Parents ☐ Guardian ☐ Father ☐ Mother ☐ Other_____

STUDENT INFORMATION ***Has your child received the following Sacraments?***

Student's Name	Grade Sept 2017	Sex M/F	School	Birthdate	Baptized Roman Catholic	Reconciliation (Confession)	Eucharist (Communion)	Confirmation
					Yes No	Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No	Yes No

Did your child attend CCD classes last year? ☐ Yes ☐ No
If not at Holy Rosary, then where?

☐ **YES!!!** I would like to volunteer as a

- ☐ Religious Education Teacher
- ☐ Religious Education Substitute Teacher
- ☐ Parent helper will assist CCD Teacher
- ☐ Auction Volunteer
- ☐ Ladies Dinner Committee Member
- ☐ Women's Retreat Planning Member

Faith Formation Program
Emergency Care Information 2017 - 2018

FOR OFFICE USE ONLY		
TEACHER	DAY	EPI PEN

STUDENT NAME: _____ **GRADE:**_____ **BIRTHDATE:** _____

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STUDENT NAME: _____ **GRADE:**_____ **BIRTHDATE:** _____

STUDENT NAME: _____ **GRADE:**_____ **BIRTHDATE:** _____

PARENT/GUARDIAN NAME: _____ RELATIONSHIP: _____

CELL PHONE: _____ WORK PHONE: _____ OTHER: _____

PARENT/GUARDIAN NAME: _____ RELATIONSHIP: _____

CELL PHONE: _____ WORK PHONE: _____ OTHER: _____

HOME ADDRESS: _____ CITY & ZIP _____

HOME PHONE: _____ EMAIL: _____

Persons other than parents authorized to be notified and/or to pick up my/our child(ren) in case of emergency or if parent/guardian cannot be reached (must list at least two):

NAME: _____ RELATIONSHIP _____ PHONE _____

NAME: _____ RELATIONSHIP _____ PHONE _____

NAME: _____ RELATIONSHIP _____ PHONE _____

CONSENT FOR TREATMENT

(I)(We), the undersigned parent(s) or legal guardian(s) of the above name child(ren), a minor, do hereby authorize a representative of **Holy Rosary Religious Education** as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medicine Practice Act, on the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the above mentioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care that the above-mentioned physician in the exercise of his or her best judgment may deem advisable.

This authorization shall remain effective until **June 30, 2018**, unless sooner revoked in writing and delivered to the above-mentioned agent(s).

I understand the parish does not assume responsibility for payment of a physician in any case. However, in an emergency, the parish may choose a physician? Yes_____ No_____

Parent/Guardian Signature _____ Date _____

Family Physician: _____ Phone _____

Address: _____ City/Zip _____

Medical Plan: _____ Plan # _____ Group _____

Does any child have a **medical problem**? Name of Child _____

Nature of medical problem? _____

Does any child have a **disability**? Name of Child _____

Nature of disability? _____

Does any child have a **food allergy**? Name of Child _____

Nature of food allergy _____

***** COMPLETE AND SIGN BACK OF FORM *****

Faith Formation Program
Emergency Care Information 2017 - 2018 (continued)

Please list any additional information here:

_____

_____

_____

_____

_____

_____

Picture Release Statement

I hereby grant permission for my child(ren) to be photographed and or videotaped. I understand that my child(ren) may be photographed at any time. I further grant permission for the photographs to be published on Holy Rosary Church website, Church Bulletin and/or Parish Newsletter.

Name of Parent (*please print*) _____ Relationship to child: _____

_____ Agree Parent/Guardian Signature _____ Date _____

_____Disagree Parent/Guardian Signature_____ Date _____