

ST. JUSTIN MARTYR PARISH SCHOOL OF RELIGION PRE-REGISTRATION FORM

Child's Full Name: _____ Birth Date: _____
(Last) (First) (MI)

Home Phone: _____ Cell Phone: _____

Address: _____ Zip: _____

E-mail Address: _____

Grade entering in Fall of 2017: _____ at _____ School

Father's Name: _____
(Last) (First)

Mother: _____
(Last) (First) (Maiden)

Child lives with: Both Parents Mother Father Other _____

Special Learning Needs: _____

FAMILY IS REGISTERED AT (Parish Name): _____

SACRAMENTAL INFORMATION:

Baptized at _____ on _____ (Name of Church) (City) (State) (Date)

Note: All Students will need to furnish a copy of the baptismal certificate if not baptized at SJM

Reconciliation / Eucharist: _____
(Church) (City) (State) (Dates)

Confirmation: _____
(Church) (City) (Sate) (Date)

REGISTRATION AND BOOK FEES FOR PSR: An \$80 / Family fee is due at the time of PSR registration. This \$80 Registration fee is applied to your book fee(s). The book fee is \$80 per child which covers costs of texts and supplies for student.

ADDITIONAL SIBLINGS PARTICIPATING IN PSR 2017-18:

Name	Grade (2017-18)	School Attending	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE COMPLETE BACK SIDE OF FORM

EMERGENCY INFORMATION: In case of an emergency and parents are not available, contact:

1. _____
(Name) (Relationship) (Phone number)

2. _____
(Name) (Relationship) (Phone Number)

Physician's Name: _____ Phone: _____

Hospital Preference: _____

MEDICAL CONDITIONS OF STUDENT(S):

Child's Name: _____

___ Allergies ___ Asthma ___ Diabetes ___ Seizures

___ Medications ___ Heart Problems ___ Recurring Illness ___ Other

Child's Name: _____

___ Allergies ___ Asthma ___ Diabetes ___ Seizures

___ Medications ___ Heart Problems ___ Recurring Illness ___ Other

Child's Name: _____

___ Allergies ___ Asthma ___ Diabetes ___ Seizures

___ Medications ___ Heart Problems ___ Recurring Illness ___ Other

IN CASE OF ILLNESS AND PARENT CANNOT PICK UP STUDENT FROM PSR, PARENTS MUST GIVE TELEPHONE PERMISSION FOR PERSON(S) LISTED BELOW TO PICK UP CHILD:

1. _____
(Name) (Relationship) (Phone)

2. _____
(Name) (Relationship) (Phone)

In case of accident or serious illness, and we and the people I designated are unable to be reached, I hereby authorize the school to call the physician and to follow his/her instructions. If this physician is unable to be contacted, the school may make whatever arrangements are deemed necessary.

Parent / Guardian Signature _____ Date _____