

HOLY FAMILY RELIGIOUS EDUCATION

Registration Form – 2023/24

Please fill out 1 form per child: _____ New Student _____ Returning Student _____ Male _____ Female
Student Data: *Please fill out as necessary.*

Last Name: _____ First: _____ Middle: _____ Birth Date: _____

Address: _____ Apt.# _____ Zip Code: _____ Telephone# _____

Email add.: _____ Owner: _____

Mother/Guardian name: _____ Daytime or cell phone #: _____ Religion _____

Address (if different): _____

Father's name: _____ Daytime or cell phone #: _____ Religion _____

Address (if different): _____

Mailing Name: _____ Address _____

All correspondence will be sent to the home address of the child, unless otherwise indicated.

School child will attend in September: _____ Grade in September 2023: _____

Is your child in the NYC Board of Education Special Education Program: _____ Yes _____ No

New Students:

Where was previous Religious Education begun: _____ Grade Completed _____ None _____

Are you a registered member of Holy Family Parish? Yes No

Do you wish to be added to the Parish records? Yes No

Would you like to volunteer as a Teacher or Substitute Teacher? Yes _____ No _____

Sacramental record: If not previously submitted, please attach a copy of your child's Baptismal Certificate even if Baptism was performed at Holy Family Church.

Sacrament	Dates	Parish	Location
Baptism			
Reconciliation			
First Communion			

Class Time: Sunday 9:30am – 12:15pm **Religious Education Grade for 2023/2024:** _____

Registration Fee \$100.00 per child, 2 children \$150.00, 3 children or more \$180.00

Sacramental Offering: First Communion \$50.00 Confirmation \$80.00

Registration check list:

Birth Certificate Baptismal Certificate Registration Fee

Office use:

Fee rec'd date:	Amount Paid:	Cash/Check #:	Receipt #:

Emergency Information

CHILD'S NAME: _____

Who is authorized to pick up your child from religious education classes?

Emergency contacts

1)

full name _____ relationship to child _____

tel. # _____ cell # _____ pager # _____

2)

full name _____ relationship to child _____

tel. # _____ cell # _____ pager # _____

In case of emergency, the Director of Religious Education will attempt to contact the parent/guardian before calling child's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician name _____ Tel. # _____

List of medication regularly taken _____

Please check all that apply:

- | | | | | |
|--|-------------------------------------|--------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> Allergies (specify) _____ | | | | |
| <input type="checkbox"/> Hearing Problems (specify) | <input type="checkbox"/> left ear | <input type="checkbox"/> right ear | <input type="checkbox"/> hearing aids | |
| <input type="checkbox"/> Vision problems (specify) | <input type="checkbox"/> glasses | <input type="checkbox"/> contacts | <input type="checkbox"/> blindness | |
| <input type="checkbox"/> Physical handicap (specify) | <input type="checkbox"/> wheelchair | <input type="checkbox"/> crutches | <input type="checkbox"/> paralysis | |

Does the child carry an *Epi-Pen*? Yes No

Does s/he know how/when to use it appropriately? Yes No

Is there any information you would like the teacher to know about your child?

I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment

Signature _____ Date _____