

PSR    TEEN FAITH PROGRAM    CONFIRMATION    CATECHIST/LEADER    CHILDRENS LITURGY    AIDE/VOLUNTEER    SMS STUDENT    HOME SCHOOLED

**GENERAL INFORMATION:**

First Name: \_\_\_\_\_  M  F  
 Last Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Mailing City: \_\_\_\_\_ Mailing State: \_\_\_\_\_ Mailing Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
 Family's Email Address: \_\_\_\_\_

**FAMILY INFORMATION:**

Is the family formally registered at St. Mary's Parish  Yes  No

\*\*Father's First Name: \_\_\_\_\_  
 Father's Religion: \_\_\_\_\_  
 \*\*Mother's First Name: \_\_\_\_\_  
 \*\*Mother's Maiden Name: \_\_\_\_\_  
 Mother's Religion: \_\_\_\_\_  
 Child lives with: \_\_\_\_\_

\*\* Please provide full baptismal names to verify/complete Parish Registry information.

**STUDENT INFORMATION:**

Date of Birth: \_\_\_\_\_ City of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_  
 School Attending in Fall: \_\_\_\_\_ Grade Entering: \_\_\_\_\_  
 Student's Email Address: \_\_\_\_\_ Student's Cell Phone: \_\_\_\_\_  
 Student currently supported with IEP or 504 Plan:  YES  NO

**LEADER INFORMATION:**

Registration Date: \_\_\_\_\_  
 Position Requested: \_\_\_\_\_  
 Employment Papers Filed: \_\_\_\_\_  
 Diocese Policy Signed: \_\_\_\_\_  
 Virtus Trained: \_\_\_\_\_  
 Background Filed: \_\_\_\_\_  
 Code of Conduct Signed: \_\_\_\_\_

**SACRAMENTAL INFORMATION:**

Baptism Date: \_\_\_\_\_  
 Baptism Church: \_\_\_\_\_  
 Church Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 First Communion Date: \_\_\_\_\_  
 First Communion Church: \_\_\_\_\_  
 Church Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**OFFICE USE ONLY:**

Date Rec'd: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Check Date: \_\_\_\_\_ Check No/Cash: \_\_\_\_\_ Initials: \_\_\_\_\_

Parish School of Religion  
Medical Information Form -- 2009-2010

St. Mary's Religious Education Office  
265 Baker Street, Berea, Ohio 44017 Telephone: 440-243-8221 Fax: 440-243-8411

**MEDICAL INFORMATION:**

Student's Name: \_\_\_\_\_

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under the authority of the Parish School of Religion when parents/guardians cannot be reached.

- I give my consent for treatment in the event reasonable attempts to contact me at \_\_\_\_\_ or other parent/guardian at \_\_\_\_\_ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by (preferred doctor) \_\_\_\_\_ or (preferred dentist) \_\_\_\_\_ (preferred doctor phone) \_\_\_\_\_ (preferred dentist phone) \_\_\_\_\_ or in the event the designated preferred physician is not available, by another licensed physician or dentist; and (2) the transfer of the child to (preferred hospital) \_\_\_\_\_ or any reasonably accessible hospital.

This authorization does not cover any major surgery unless the medical opinions of (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I do not give my consent for treatment

In the event of illness or emergency treatment required, I wish the PSR authorities to: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Are there any special needs (medications, allergies, asthma, diabetes, etc...) we should be aware of in order to better serve your child? (If none, please write "None known at this time."):  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Name 2: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Emergency Contact Phone 2: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_