St Colette Parish School Catholic Formation
Registration for First Grade and New Students

Date _____ Amount Paid _____

Full Name _____Grade _____

Address_____ Circle One: Male or Female
Circle One: In School or Home School

City & Zip code _____

Phone Number _____

Date of Birth _____

Mother's Maiden Name _____ Religion _____

Father's Name _____ Religion _____

Public School Attending _____

Student lives with: _____ Natural Mother _____Natural Father
_____Custodial Mother _____Custodial Father _____Guardian

Parish Now Attending _____

Sacramental History:
Church of Baptism _____
City/State _____
Date _____

Church of First Penance _____
City/State _____
Date_____

Church of First Communion_____
City/State _____
Date_____

Church of Confirmation_____
City/State _____
Date _____

Other Students Attending Our PSR Program

Name	**Grade**
_____	_____
_____	_____
_____	_____

(over)

Saint Colette
Parish School of the Catholic Formation

Child's Name

Street Address City/State
Zipcode

Home Phone Email

COMPLETE EITHER PART I OR II BELOW

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact a parent/guardian have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the designated preferred physician or dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to the preferred hospital reasonably accessible.

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Name of Other Person to Contact: _____

Relationship to Child: _____ Phone: _____

Preferred Physician: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Medical Specialist (If applicable): _____ Phone: _____

Preferred Hospital: _____ Phone: _____

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.

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, PHYSICAL IMPAIRMENTS, LEARNING IMPAIRMENTS THAT WE OR A PHYSICIAN SHOULD KNOW:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

_____

_____

PART II: REFUSAL TO CONSENT (DO NOT COMPLETE IF YOU HAVE SIGNED PART I)

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

_____

Parent/Guardian Signature: _____Date: _____