2024 - 2025 CCD Registration

Blessed Sacrament Parish
St. Elizabeth Ann Seton Parish
Sts. Mary & Joseph Parish

Student Information

First______________ Middle______________ Last ________________________

Address,____

Date of Birth: ______ / ______ / __________ Male ______ Female ________

Grade entering ________ School ____

Sacraments Celebrated

	Date (mm / Year)	Church	City/ State
Baptism			
1st Reconciliation			
1st Eucharist			
Confirmation			

Parent Information

Name: Mother________________________ Phone ____________________

Text Y______ N _____

Email ____

Father__________________________ Phone ____________________

Text Y______ N _____

Email ____

Student lives with: ____

Parish where family is registered ____

For Office use Only***: $30 per student fee ($50 per family) for Faith Formation.***

Check ________ *Cash* _______ *eGiving* ________ *Amount paid* __________ *Date* _____________

(over)

2024 - 2025 MEDICAL / EMERGENCY FORM

Date ______________________________

Student Name _________________________________

Emergency Contact ______________________________Phone_____________
(Name) (If parents are unavailable)

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care provider's and local hospital to be called:

Physician______________________________ Phone _____________________

Dentist _______________________________ Phone _____________________

Hospital _______________________________ E.R. Phone _________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonable accessible.
Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a doctor should be alerted:

ALLERGIES / MEDICAL CONDITIONS:

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____

Signature of Parent/ Guardian _______________________ Date______________________

Relationship to student________________________________

PART 2: REFUSAL TO CONSENT

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

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Signature of Parent/ Guardian_______________________ Date ________________

Relationship to Student____________________________