

# RELIGIOUS FORMATION PROGRAM REGISTRATION FOR 2009-2010

## FAMILY INFORMATION *(Please Print)*

<u>To whom should mail be addressed:</u>	<u>Parent's First Names:</u>
<u>Address</u>	
<u>City/State/ZIP</u>	
<u>Father's Daytime Phone:</u>	<u>Mother's Daytime Phone</u>
<u>Father's Home / Cell Phone:</u>	<u>Mother's Home / Cell Phone</u>
<u>Father E-mail:</u>	<u>Mother E-mail:</u>
If we need to reach you during the day, would you prefer we contact: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Either	

## STUDENT'S INFORMATION *(Please only list children involved in the programs)*

Child's Name:	Grade:	Program:
	Birth Date:	<input type="checkbox"/> Early Childhood <input type="checkbox"/> Faith in Life Formation <input type="checkbox"/> Tuesday Night Alive
Child's Name:	Grade:	Program:
	Birth Date:	<input type="checkbox"/> Early Childhood <input type="checkbox"/> Faith in Life Formation <input type="checkbox"/> Tuesday Night Alive
Child's Name:	Grade:	Program:
	Birth Date:	<input type="checkbox"/> Early Childhood <input type="checkbox"/> Faith in Life Formation <input type="checkbox"/> Tuesday Night Alive
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Office Use Only:	Received By:	Date Rec'd:
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## AUTHORIZATION FOR MEDICAL TREATMENT

- This authorizes Aquinas Newman Center to seek medical assistance for your child(ren) in the unlikely case of an emergency.
- If you choose not to complete and sign the **Authorization for Medical Treatment**, please indicate at the bottom of the page how we should address medical emergencies with your child(ren)

Name of Parent or Guardian:		Insurance Carrier and Policy #
Address		
City / State / Zip		
Home Phone		Primary Physician's Name and Phone #
<b>Child 1</b>	Name	Birth Date
<b>Child 2</b>	Name	Birth Date
<b>Child 3</b>	Name	Birth Date
<b>Child 4</b>	Name	Birth Date
<b>Child 5</b>	Name	Birth Date

I hereby authorize the treatment, administration of anesthesia, surgical treatment(s) for my minor child(ren), listed above, in the event of a medical situation occurring in my absence or when the hospital or physicians are unable to contact me. This authorization extends to any hospital, physician(s), and nursing personnel within the physician's staff where treatment is rendered.

I release from medical responsibility and liability the hospital, physician(s) and nursing personnel for performing medical procedures and acting on the authority of this medical treatment consent form which such medical providers deem necessary for my minor child.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 2009, and valid from today through 5/30/10

\_\_\_\_\_  
Signature of parent/guardian

Please describe any medical conditions/issues (drug/food allergies, medications) for the above child(ren) that their catechists should be aware of:

***If you chose to not sign the above, what should we do in the event of an emergency in your absence:***