ST. JOHN BREBEUF RELIGIOUS EDUCATION 2018/2019

PLEASE PRINT:

FAMILY NAME: HOME PHONE NO.

ADDRESS: CITY: STATE: ZIP:

FATHER'S NAME: OCCUPATION: RELIGION:

BUSINESS PHONE: FATHER'S CELL PHONE NO.

MOTHER'S NAME: OCCUPATION: RELIGION:

BUSINESS PHONE: MOTHER'S CELL PHONE NO.

WILL ATTEND **WEDNESDAY EVENINGS FROM 5:00 - 6:30 P.M.** CIRCLE PREFERRED DAY: WEDNESDAY

WILL ATTEND **THURSDAY EVENINGS FROM 6:30 - 8:00 P.M.** CIRCLE PREFERRED DAY: THURSDAY

FILL IN INFORMATION **ONLY FOR CHILDREN IN PROGRAM.** **NEW STUDENTS:** COPY OF BAPTISM CERTIFICATE REQUIRED

STUDENT'S FULL NAME	Gender M or F	BIRTH DATE MO/DAY/YR	GRADE (Fall, 2018)	BAPTISM (MO/DAY/YR/CHURCH)	EUCHARIST YES or NO	RECONCILIATION YES or NO	CONFIRMATION YES or NO

E-MAIL ADDRESS: ____________________

PLEASE INDICATE BELOW ANY ADDITIONAL INFORMATION WE NEED TO KNOW ABOUT YOUR CHILD/REN; FOR EXAMPLE, ANY LEARNING DISABILITIES, ALLERGIES, MEDICAL AND/OR BEHAVIORAL PROBLEMS, OR SPECIFIC WAY YOUR CHILD LEARNS BEST, ETC.

IF DIVORCED, WHO HAS CUSTODY OF CHILDREN?

NAME OF SCHOOL STUDENT(S) ATTENDS:

FOR OFFICE USE ONLY **FOR OFFICE USE ONLY**

Tuition Payments: ____________ ____________

CHURCH ENVELOPE # ____________
COPY OF CHURCH ENVELOPE REQUIRED

→ Please write your check payable to: St. John Brebeuf Religious Education

→ Please send all Registration items to: St. John Brebeuf Religious Education Program
8301 North Harlem Avenue
Niles, Illinois 60714

ST. JOHN BREBEUF
2018/2019 RELIGIOUS EDUCATION PROGRAM
MEDICAL INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT
MEDICAL/ EMERGENCY INFORMATION

Name	Grade	Medical allergies/significant medical history	Are child's immunizations current? (Y or N)

Mother's Name ______________ Home # ______________ Business # ______________

Father's Name ______________ Home # ______________ Business # ______________

Name of Physician ______________ Phone # ______________

Address ______________

Medical Insurance Company ______________

Insurance Number ______________

Other contact in case of emergency:

Name ______________ Phone ______________

Relationship ______________

MEDICAL RELEASE

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of the Director, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child, I (we) hereby request and authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Date or Dates for which release is intended: September, 2018 through May, 2019

______________ Parent/Guardian Signature ______________ Date

______________ Parent/Guardian Signature ______________ Date

NOTE: IF THIS INFORMATION CHANGES DURING THE YEAR, PLEASE BE SURE TO INFORM THE RELIGIOUS EDUCATION OFFICE IMMEDIATELY.