

ST. JOHN BREBEUF RELIGIOUS EDUCATION

2019/2020

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 <small>M or F</small>	BIRTH DATE <small>MO/DAY/YR</small>	GRADE <small>(Fall, 2019)</small>	BAPTISM <small>(MO/DAY/YR/CHURCH)</small>	EUCARIST <small>YES or NO</small>	RECONCILIATION <small>YES or NO</small>	CONFIRMATION <small>YES or NO</small>

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
2019/2020 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, 2019 through May, 2020

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.