St. Alphonsus & St. Joseph

Parish School Religion (PSR) Registration 2021-2022

Please write in complete full names for all three: Need middle name for sacrament certificates.

Last_____First_____Middle_____

Birthdate_____ Age_____

Grade Entering_____ School Attending_____

Address_____

Home Phone _____ Cell_____ E-mail_____

I prefer notifications be sent by (circle one): Cell phone text message email home phone

Mother's Name (include maiden name) _____

Father's Name_____

Step Parent's Name(s)_____ _____

We are currently registered at (name of parish) _____

Sacramental History:

Baptized: yes no Where _____ Date _____

1st Reconciliation: yes no Where _____ Date _____

1st Communion: yes no Where _____ Date _____

Confirmation: yes no Where _____ Date _____

_____ I will teach religion classes to my child at home using materials provided by the parish.

_____I will be attending an area PSR at _____

*Please return this form **ASAP** either by mailing to or dropping off at the parish office; dropping it in the Sunday collection basket; or mailing it to Diane Wasiniak (PSR Director) at 1620 State Rte 61, Norwalk, Ohio 44857.*

St. Alphonsus & St. Joseph PSR 2021-2022

EMERGENCY MEDICAL AUTHORIZATION/PERMISSION FORM

Phone number where a parent can be reached during PSR hours_____

Purpose – to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under PSR authority, when parents or guardians cannot be reached.

Name of Relative or Childcare Provider FOR EMERGENCY CONTACT:

_____Relationship_____

Phone: _____alternate phone: _____

TO GRANT CONSENT:

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

Physician: _____Phone:_____

Dentist: _____ Phone: _____

Hospital: _____ 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 preferred practitioner is not available, by another licensed physician or dentist;
2) The transfer of the child to any hospital reasonably accessible.

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.

Please list any pertinent facts concerning the child's medical history to which we and a physician should be alerted:

ALLERGIES: _____

MEDICATIONS: _____

SPECIAL NEEDS: _____

OTHER MEDICAL INFO: _____

PERMISSION RELEASE for my child's picture to be taken and used in brochures, video, CD/DVD's websites etc. for publicity use only.

____I grant permission ____I do NOT grant permission

Date_____ Signature of Parent of Guardian_____