

St Joseph Parish
Religious Education Registration
 670 West Main Street, Plain City, OH 43064

Family Last Name: _____

Date: _____

Home Address: _____

Home Phone: _____

Mom/Dad Work/Cell: _____

Emergency Contact: _____

Mother's Maiden: _____

Custodial Parent, if different from above: _____

Email: _____

Home Address: _____

Both Parents Catholic? Y ___ N ___

Child	Birthdate	Sex	Grade	Session	Room	Class
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Sacrament and Date: Baptism Catholic? Eucharist Penance Confirmation

_____ _____ _____ _____ _____

Special Needs: medical, learning disabilities, physical disabilities: _____

Child	Birthdate	Sex	Grade	Session	Room	Class
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Sacrament and Date: Baptism Catholic? Eucharist Penance Confirmation

_____ _____ _____ _____ _____

Special Needs: medical, learning disabilities, physical disabilities: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT At the time of an emergency, in the event reasonable attempt to contact me have been unsuccessful, I hereby give my consent for any treatment deemed necessary by the preferred listed doctor or dentist, or in the event the listed doctor/dentist is not available, by another licensed physician or dentist. I also agree to the transfer of my child(ren) to any reasonably accessible hospital where further consent will be obtained before treatment.

Preferred Physician: _____

Phone: _____

Preferred Dentist: _____

Phone : _____

NON-CONSENT FOR MEDICAL TREATMENT I do not give my consent for emergency medical treatment of my child(ren). In the event of illness/injury, I wish St. Joseph to take the following actions:

Signature: _____

Date : _____