

**St. Joseph Parish, Colbert**  
**Religious Education Registration**

FAMILY NAME: \_\_\_\_\_ HOME NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_

CELL NUMBER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_

CELL NUMBER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

REGISTERED IN PARISH? \_\_\_\_\_ IF NOT, PLEASE FILL OUT PARISH CENSUS CARD.

Student's Name	Grade	School	Cell & Carrier	Email

*We appreciate your prompt payment so that our expenses can be paid. Thank you.*

**TUITION FEES:**

*\$30.00 – 1 child; \$60.00 – 2 children; \$80.00 – 3 children; \$100.00 – maximum*

**Total Tuition Fee Due:** \_\_\_\_\_ **Paid:** \_\_\_\_\_ **Date:** \_\_\_\_\_

St Joseph Parish  
 Religious Education  
 Medical Information 2011-2012

Children (first & last name)	Grade	Date of Last Tetanus Shot
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

Emergency Contact:

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Other: \_\_\_\_\_

Address: \_\_\_\_\_

Home ph # \_\_\_\_\_ Work ph # \_\_\_\_\_ Cell # \_\_\_\_\_

Family Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Children's Name	Medical Condition (ie: diabetes, asthma)	Allergy (food, drugs, environments, animals)	Comments (inhalers, activity limitations, special diet,
1			
2			
3			
4			
5			

# Medical Release

Please initial appropriate statements

Initial both statements here { I authorize St Joseph Parish, their staff and or volunteers to procure medical, hospital or dental care for my child(ren) in the event of injury or illness if I cannot be contacted to make arrangements for such treatment. It is understood by me that the expense of this service will be accepted by me.

**OR**

I authorize St Joseph Parish, their staff and or volunteers to administer first aid to my child(ren) should the situation warrant. In addition, I agree to release and hold harmless the above mentioned for any ill effect resulting from the administration of said first aid.

Initial just this statement I do not authorize St Joseph Parish, their staff or volunteers to oversee any medical treatment of my child(ren) in my absence.

Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_