



BLESSED SACRAMENT PARISH RELIGIOUS EDUCATION REGISTRATION 2011-2012



FAMILY LAST NAME _____

Registered Member of parish Yes ~ Approx. Date _____
 No

To be considered a "Registered Parishioner" the parish and school have the following criteria:

- Regular attendance at weekend liturgies.
- Parish registration form filled out.

Non-parishioner ~ Parish _____

For office use only

Registration date: _____

Payment type: _____

Amount received: _____

Submit one registration form per family.

Registration fees payable to Blessed Sacrament Parish

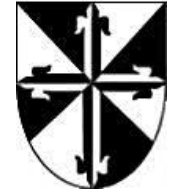
<u>FEES</u>	<u>Grades</u>	<u>1 child</u>	<u>2 children</u>	<u>Maximum</u>
Parishioners	1-8	\$ 90.00	\$180.00	\$200.00
Non-parishioners	1-8	\$150.00		\$300.00
Sacramental Fee	2	\$ 45.00		

Scholarship Requested

ENTERING GRADE <small>(11-12 school year)</small>	CHILD'S NAME	M/F	BIRTHDATE <small>(MM/DD/YY)</small>	FEES <small>(\$)</small>	School student attends	Please check SACRAMENTS RECEIVED			
						Bap	Rec.	Euc.	Con.
Total Fees									



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Family Contact Info:	
Mother _____	Father _____
Address _____	Address _____
City _____ Zip _____	City _____ Zip _____
Home phone: _____	Home phone: _____
Work phone: _____	Work phone: _____
Cell phone: _____	Cell phone: _____
Email address _____	Email address _____
Occupation: _____	Occupation: _____

Family Contact Info:	
Physician _____	Physician's Phone: _____

Clinic/Hospital Preference _____	Clinic/hospital phone _____

Health Insurance Carrier _____	Policy# or Group # _____

<i>(optional)</i>	<i>(optional)</i>
<i>Medical Liability Release Statement: In the event that neither parent nor emergency contact can be reached, I give my permission for an adult member of Blessed Sacrament Parish Religious Education staff-volunteer corps to administer necessary first aid and/or transport my child(ren) (by ambulance) to the above mentioned clinic or associated hospital for medical care and treatment as deemed appropriate. I will not hold Blessed Sacrament Parish, the Diocese of Madison or any staff/volunteer liable for any injuries my child(ren) may incur while participating in this supervised program.</i>	
Parent Signature _____	Date _____

Additional Contact (other than Parent):
<input type="checkbox"/> Mailings should also be sent to this address
<i>Please print</i>
Name _____
Phone _____
Address _____

Cell phone _____
City _____
Zip _____

Health Concerns
Please indicate any physical conditions, learning challenges, allergies, and/or family circumstances. This information will be kept confidential.
