

Mother's Full Name:	Father's Full Name:
Marital Status Married Divorced Widow (Circle one) Remarried Separated Single	Marital Status Married Divorced Widower (Circle one) Remarried Separated Single
(Please provide the following if different from above.) Address: _____ Home Phone: _____ Cell Phone: _____	(Please provide the following if different from above.) Address: _____ Home Phone: _____ Cell Phone: _____
Work Phone: _____ Ext. _____	Work Phone: _____ Ext. _____
Occupation: _____	Occupation: _____
Parish Registered In: _____	Parish Registered In: _____
Religion: _____	Religion: _____

MEDICAL INFORMATION & LEARNING NEEDS: Include medications, allergies, and other requirements. Any information about your child's strengths, weaknesses, and personal characteristics (shy, hyper, extrovert) are helpful for teachers to make the most of each student's classroom experience. (Please be specific regarding this information. This is for your child's benefit.)

EMERGENCY INFORMATION** (MUST BE COMPLETED AND SIGNED TO BE PROCESSED)**	
In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of the Director of Religious Education responsible for the Religious Education program, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of _____, I (we) hereby request and authorize any of the aforesaid personnel to obtain for my 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(s) for which release is intended: I understand this release is intended to cover all scheduled Religious Education classes and events which my child attends in the 2017-18 catechetical year.	
Signature _____	Date _____
Emergency Contact _____ (Other than parent): _____	Home Phone: _____ Cell Phone: _____ Relationship to child: _____
Emergency Contact _____ (Other than parent): _____	Home Phone: _____ Cell Phone: _____ Relationship to child: _____
Family Physician: _____ Phone: _____	