2017- 2018 RELIGIOUS FORMATION ENROLLMENT FORM

Registration Date:______________

Amt Paid:______________ Cash CK

FAMILY'S LAST NAME:______________________________ Address:__________________________ City:_______________ Home Phone:______________

Father's Name:____________________________________ Cell Phone:________________________

Mother's Name:____________________________________ Cell Phone:________________________

Email:

Emergency Contact Name & Phone:____

Parish you are registered at:

______________________________City:________________

Out of Parish Fee of $50 added if not registered at Sacred Heart

SEE THE REVERSE SIDE OF THIS FORM FOR THE MEDICAL TREATMENT RELEASE FORM.

THIS INFORMATION IS REQUIRED BY THE ARCHDIOCESE OF DETROIT.

Student Name:______________________ Date of Birth:______________________ Special needs: ______________________	**IMPORTANT: Copy of Baptism certificate required if not baptized at Sacred Heart** Church of Baptism:______________________ City/State:______________________ Received First Communion? Yes ☐ No ☐	Grade:__________ Sunday ☐ Monday ☐ After-School Program ☐ ($15 Fee / Child)
Student Name:______________________ Date of Birth:______________________ Special needs: ______________________	Church of Baptism:______________________ City/State:______________________ Received First Communion? Yes ☐ No ☐	Grade:__________ Sunday ☐ Monday ☐ After-School Program ☐ ($15 Fee / Child)
Student Name:______________________ Date of Birth:______________________ Special needs: ______________________	Church of Baptism:______________________ City/State:______________________ Received First Communion? Yes ☐ No ☐	Grade:__________ Sunday ☐ Monday ☐ After-School Program ☐ ($15 Fee / Child)
Student Name:______________________ Date of Birth:______________________ Special needs: ______________________	Church of Baptism:______________________ City/State:______________________ Received First Communion? Yes ☐ No ☐	Grade:__________ Sunday ☐ Monday ☐ After-School Program ☐ ($15 Fee / Child)

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: ______________________ Relationship to you: ____________

Reason for which release is intended: ______________________________

Address of Minor: ______________________ City: ______________

Emergency Phone(s): ______________________

Family Physician: ______________________ Phone: ______________

Physician Address: ______________________ City: ______________

List allergies, medication, contract, or other pertinent comments:

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Health Insurance Data:

Company: ______________________ Policy: ______________________

Group: ______________________ Contract: ______________________

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: ____________________ Signed: ______________________
(Parent or Guardian)