

Placement:

Religious Education Registration

Student's Name			Gender	Birth Date	Place of Birth	Grade
Last	First	MI	(M/F)	MM/DD/YY	City, State, Country	PK-12th
Sacrament	Sacrament Received Yes or No	Date MM/DD/YY	Church	City, State		
Baptism						
First Confession						
First Eucharist						
Confirmation						

Family Name: _____ Parish Member? Y/N: _____

Primary Address: _____ City: _____ Zip: _____
(Street) (Apt.)

Contact Info: (____) _____ - _____ (____) _____ - _____ (E-mail)
(Home Phone) (Cell / Other)

Father/Guardian: _____ (____) _____ - _____
(Last) (First) (MI) (Phone)

Mother/Guardian: _____ (____) _____ - _____
(Last) (First) (Maiden) (MI) (Phone)

Emergency Contact Information

1. _____ (____) _____ - _____
(Last) (First) (Relationship) (Phone)
2. _____ (____) _____ - _____
(Last) (First) (Relationship) (Phone)

REGISTRATION FEES: **\$35.00 – 1 Child**
 \$40.00 – 2 Children
 \$45.00 – 3 or more **Fees reduced/waived upon request*

FOR OFFICE USE ONLY

Reg Date: _____ No. of Children: _____

Fee Due: _____ Teacher: YES NO

Amt Paid: _____ Check # or Cash: _____

Please Complete Reverse Side

Parish Contact Information

Phone: 361-358-3239
 Fax: 361-358-4270
 www.stjosephbeeville.org



2010-2011 CCE Parent/Guardian Permission & Liability Waiver

I, _____, grant permission for my son/daughter, _____
Parent or Guardian's Name Child's Name

to participate in St. Joseph's Religious Education classes and activities. These activities will take place under the guidance and direction of parish employees and/or volunteers from St. Joseph's Church.

As a parent/guardian, I remain legally responsible for any personal actions taken by son/daughter named above.

I agree to hold harmless St. Joseph's Church, its officers, directors, agents, and the Diocese of Corpus Christi from any liability for illness or death arising from or in connection with my son's/daughter's attending the above named event.

Medical Consent & Permission to Treat

To the best of my knowledge, my child, _____ is in good health, and I assume all responsibility for the health of my child.

In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

If you are unable to reach me, please contact:

Name: _____

Relationship to me or my son/daughter: _____

Home Phone: _____ Alternate Number: _____

Insurance Carrier: _____ Policy Number: _____

My son/daughter is taking medication: _____

*My son/daughter is allergic to the following: _____

Parent/Guardian Signature

Date