

**St. Mary Parish Religious Education
2021-2022**

Family last name _____ Best Contact Phone# _____

Family Email address _____

Address _____ City/Zip _____

Father's first & last name _____ Cell _____

Address (if different from child's) _____

Mother's first & last name _____ Cell _____

Address (if different from child's) _____

Father's Religion _____ Mother's Religion _____

What Parish is your family registered at? _____ Envelope # _____

Did your child attend Religious Ed. at St. Mary's last year? _____ If not
then where did your child attend? _____

Religious Education classes meet:

Grades 1-6: Sunday 10:00-11:00 am.

Grades 7-8: Wednesday 7:00-8:30 pm. Please refer to the Religious Education Calendar,
schedule varies

Tuition rates are as follows:

There is a family fee of \$35.00 per family. Tuition per child is \$55.00

Total Cost for: One Child- \$90.00(35.00 family fee/55.00 tuition)

Two children- \$145.00 (35.00 family fee/110.00 tuition)

Three children-\$200.00 (35.00 family fee/165.00 tuition)

Student Name	M/F	Birth Date	School&Grade	Religious Ed. time and day
<i>First and last (if different from family name)</i>				

Confidential Use Only: Does your child/children have any disabilities/allergies that the teacher should be aware of? _____ If yes please give the name of the child and a brief explanation _____

Are there any court orders regarding any of the children that we should be aware of: _____

Please initial on the line if you do NOT want your child/children's image to be used for "not for profit" publications such as church bulletin, community newspapers, social media, marketing brochures, etc. _____

Parent Signature _____ Date _____

Please fill out medical treatment release form on the back

Office use only Paid: Cash _____ Check _____ Date received _____

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:

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. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: _____

Signed: _____

(Parent or Guardian)