

EMERGENCY CONTACT/ MEDICAL INFORMATION:

If we are unable to reach you, whom should we contact?

Name: _____ Relationship: _____

Phone Number (home) _____ (cell) _____

I give permission for my child's picture to appear on the parish name website, bulletin boards, newspaper articles in relation to events that happen in the parish. (please check box if you agree)

CONSENT FOR MEDICAL CARE:

I give permission that, in my absence, my children whose names appear on page 1 of this registration form, may receive emergency medical care for injuries and all situations that should occur while participating in the Religious Education Program programs and activities at St. Vincent de Paul/St. Frances Cabrini Parishes.

Signed (Parent/Legal Guardian):

Date: _____

MEDICAL LEARNING DATA (Please list/ and fill out where appropriate) :

Name of Child _____

Allergies: _____

Medications: _____

Does your child require any accommodations in learning? Yes ____ No ____

If yes, please explain

Is there anything else we should know about your child?

Parent/Guardian Signature: _____

Date: _____