DIVINE WORD PARISH

PARISH SCHOOL OF RELIGION (PSR)

Please print Clearly

Students Name: _____ Gender M/F Date of Birth:_____

Parents Name_____

Street Address_____ _____

City /State/ Zip_____ Primary Phone (_____) _____

Father's Cell phone:_____ Mother's Cell Phone_____

Parents Primary E-Mail (s) _____

Did your child attend Divine Word PSR program last year? YES NO

What School does your child attend? _____

Has your child been baptized? YES NO Received First Reconciliation? YES NO

Received First Communion? YES NO Received Confirmation? YES NO

******New Students please provide a copy of your Sacramental Certificates.**

CHOICE OF DAY for PSR 2016-2017

Sunday 9:30am – 10:50am

Prek –K ____
Grade 1 ____
Grade 2 ____
Grade 3 ____
Grade 4 ____
Grade 5 ____

Wednesday 4:30pm – 6:00pm

Prek –K ____
Grade 1 ____
Grade 2 ____
Grade 3 ____
Grade 4 ____
Grade 5 ____

Tuesday 7:00pm – 8:30pm

Grade 6 ____
Grade 7 ____
Grade 8 ____

Student Photo Release

We understand that permission is required for our child Photograph to be published in Divine Word Parish Bulletin, Monitors, app , publicity brochures and Divine Word Website. This permission is given for the duration of our childs education in Divine Words PSR program

_____ I grant Permission _____ I refuse permission Parent/Guardian signature_____

Please indicate any special needs (allergies, etc.) your child may have. If there are none, please write "NONE."

_____

_____

The registration fee for 2017-2018 is payable with this form: $75.00 one child, $130.00 two children, $170.00 three children, $190.00 four or more children. Make checks payable to Divine Word Catholic Church. Please note – For alternate tuition arrangements please contact Gina Rensi, Director of Religious Education at 440-256-1412.

Please prayerfully consider Volunteer Opportunities (check/circle one)

Teacher - PreK K 1 2 3 4 5 6 7 8 Substitute Teacher, Classroom Aid, Substitute, Sacramental Help

Divine Word Youth Faith Formation
Emergency Medical Authorization Form

Child's Name _____

Address: _____

Telephone: _____

Do you have medical coverage? Yes ____ No____
If yes, give: Policy Holder Name _____
Name of Plan _____
Plan Number _____

Preferred hospital which accepts your insurance:
Local: _____ Greater Cleveland: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Medication child is taking: _____

Medication to which child is allergic: _____

Other allergies or medical problems: _____

Special dietary needs: _____

In the event reasonable attempts to contact me at (phone) _____

or (other parent) _____ at (phone) _____ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by

(preferred physician) Dr. _____ (phone) _____

or (preferred dentist) Dr. _____ (phone) _____
or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to (preferred hospital) _____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for surgery, are obtained before surgery is performed.

_____ _____
(Parent or Guardian signature) (Date)