2015-2016 FAMILY CCD REGISTRATION

PARENTS/GUARDIANS NAMES:____

STREET ADDRESS:____BOX#______

CITY: __________________________________STATE: ________ZIP:____________

PHONE#________________CELL____________________WORK________________

EMERGENCY CONTACT:____
Name Phone#

EMAIL____

PLEASE LIST THE NAME AND GRADE FOR EACH CHILD TO BE ENROLLED

All children 4 and over are eligible to be enrolled

Registration Fee: $20per Child or a family fee of $50 for 3 or more children enrolled

1. ____Grade ________Allergies?_______

2. ____Grade ________Allergies?_______

3. ____Grade ________Allergies?_______

4. ____Grade ________Allergies?_______

5. ____Grade ________Allergies?_______

Permission to publish photos:
When pictures are taken at Holy Name Church CCD or outing
I give _____ do not give____ permission to publish the picture of my child/ren in newspapers, newsletters, bulletins.

Parent/Guardians Signature______________________________________Date:___ _____

Holy Name Catholic Church realizes that a child's primary religious educator is their parents or guardians. It is a privilege to share in this duty with you the parents or guardians. We ask from you, the parents, a commitment to share in the responsibilities of making this a successful program by supporting your child's attendance, any assignments and to assist if requested by you child's catechist.

In order to insure a successful program for the children of Holy Name Catholic Church, volunteers are greatly needed and appreciated. Please indicate any of the following areas you would be able to assist in, even if on an occasional basis.

__________Teacher **______Substitute Teacher**

__________Teacher's Aide **__________Youth Ministry**

I'd like to thanks each of you for your commitment to the religious education program of our parish and to know that together everyone can make a difference for the future of our youth! Peace and Blessings!!!!

PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

MEDICAL MATTERS

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)-One child per form

CHILDS NAME: ____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship:____

Phone:_________________________________

Family Doctor:____________________________Phone:________________________________

Family Health Plan Carrier: ___________________________Policy #:____________________

Signature: ____ Date

Other medical Treatment: In the event it comes to the attention of the parish/school, its officers, directors and agents, and The Diocese of Sioux City, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: ____Date _____________________

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

____

____

Signature: ____Date _____________________

No medication of any type whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: Date

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: ____Date _____________________

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.)_____________________________

Immunizations: Date of last tetanus/diphtheria immunization:____________________________

Does child have a medically prescribed diet: ____

Any physical limitations? ____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition:_______________________________

You should be aware of these special medical conditions of my child:

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