



# Our Lady of Perpetual Help

## Parish School of Religion

2018-19 Registration

### Family Information

#### Father's Information

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_ Religion: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you wish to receive text alerts concerning class? Yes / No  
If so, who is your mobile phone provider? \_\_\_\_\_  
*(\*Please note, we cannot send messages without this information\*)*

#### Mother's Information

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_ Religion: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you wish to receive text alerts concerning class? Yes / No  
If so, who is your mobile phone provider? \_\_\_\_\_  
*(\*Please note, we cannot send messages without this information\*)*

Child's primary residence is with:

- Mother and Father
- Mother
- Father
- Mother & Stepfather: \_\_\_\_\_
- Father & Stepmother: \_\_\_\_\_
- Grandparent: \_\_\_\_\_
- Other: \_\_\_\_\_

Is your family **REGISTERED** as a member of Our Lady of Perpetual Help Parish?  
Yes / No / I don't know

Would you like to receive communications concerning OLPH athletics for your child?  
Yes / No

**Emergency Medical Authorization**

In the event of emergency, I understand **Our Lady of Perpetual Help Religious Education** will make every effort to contact me, \_\_\_\_\_ (*name and relationship*) at \_\_\_\_\_ (*phone number*) or other designated parent/guardian, \_\_\_\_\_ (*name and relationship*) at \_\_\_\_\_ (*phone number*). However, if they cannot reach me or the other designated parent/guardian, I give my permission to take my child/children for emergency treatment. I release **Our Lady of Perpetual Help Religious Education** and **Our Lady Of Perpetual Help Church**, staff and volunteers from all liability of any kind which may arise from such emergency.

**Information/Picture Waiver for Minors**

Information regarding minors could be released in various formats including websites, social media, print media and forms, unless a parent/guardian notifies the parish that such information is **not to be released** regarding his/her child/children.

This information includes names of minor, pictures of minor, grade level, and awards.

Please select the following:

- I do NOT want information (name, pictures, grade level, and awards) released.
- I give permission for information to be released.

Please sign and date below. If submitting via email, please type your legal name and date. This will serve as your electronic signature on this form. If printing and submitting a paper copy, please leave blank when printing, then sign and date before returning it to the parish office.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Student Information

## Student #1

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of birth: \_\_\_\_\_

Grade in 2018-2019 school year: \_\_\_\_\_

School Attending: \_\_\_\_\_

Has your child attended religious education classes at a different parish? Yes / No

If yes, where? Parish name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

## Medical/Physical/Educational Information

- |   |   |
|---|---|
| <input type="checkbox"/> ADD/ADHD                                   | <input type="checkbox"/> Orthopedic impairment                |
| <input type="checkbox"/> Autism                                     | <input type="checkbox"/> Speech or language impairment        |
| <input type="checkbox"/> Behavioral/Emotional disturbance           | <input type="checkbox"/> Child needs individual aide in class |
| <input type="checkbox"/> Hearing impairment<br>(including deafness) | <input type="checkbox"/> Child unable to use stairs           |
| <input type="checkbox"/> Visual impairment<br>(including blindness) | <input type="checkbox"/> Developmental disabilities           |
|   | <input type="checkbox"/> Reading difficulties                 |
|   | <input type="checkbox"/> Traumatic brain injury               |
- Other medical condition(s): \_\_\_\_\_
- \_\_\_\_\_

Other health concerns: (e.g. chronic or acute health problems such as diabetes, epilepsy, hemophilia, asthma, etc.) \_\_\_\_\_

\_\_\_\_\_

Food Allergies: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Please list any other comments or concerns regarding your child that will help him/her be successful in our PSR program this year:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Student Information

## Student #2

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of birth: \_\_\_\_\_

Grade in 2018-2019 school year: \_\_\_\_\_

School Attending: \_\_\_\_\_

Has your child attended religious education classes at a different parish? Yes / No

If yes, where? Parish name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

## Medical/Physical/Educational Information

- |   |   |
|---|---|
| <input type="checkbox"/> ADD/ADHD                                   | <input type="checkbox"/> Orthopedic impairment                |
| <input type="checkbox"/> Autism                                     | <input type="checkbox"/> Speech or language impairment        |
| <input type="checkbox"/> Behavioral/Emotional disturbance           | <input type="checkbox"/> Child needs individual aide in class |
| <input type="checkbox"/> Hearing impairment<br>(including deafness) | <input type="checkbox"/> Child unable to use stairs           |
| <input type="checkbox"/> Visual impairment<br>(including blindness) | <input type="checkbox"/> Developmental disabilities           |
|   | <input type="checkbox"/> Reading difficulties                 |
|   | <input type="checkbox"/> Traumatic brain injury               |
- Other medical condition(s): \_\_\_\_\_
- \_\_\_\_\_

Other health concerns: (e.g. chronic or acute health problems such as diabetes, epilepsy, hemophilia, asthma, etc.) \_\_\_\_\_

\_\_\_\_\_

Food Allergies: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Please list any other comments or concerns regarding your child that will help him/her be successful in our PSR program this year:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Student Information

## Student #3

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of birth: \_\_\_\_\_

Grade in 2018-2019 school year: \_\_\_\_\_

School Attending: \_\_\_\_\_

Has your child attended religious education classes at a different parish? Yes / No

If yes, where? Parish name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

### Medical/Physical/Educational Information

- |   |   |
|---|---|
| <input type="checkbox"/> ADD/ADHD                                   | <input type="checkbox"/> Orthopedic impairment                |
| <input type="checkbox"/> Autism                                     | <input type="checkbox"/> Speech or language impairment        |
| <input type="checkbox"/> Behavioral/Emotional disturbance           | <input type="checkbox"/> Child needs individual aide in class |
| <input type="checkbox"/> Hearing impairment<br>(including deafness) | <input type="checkbox"/> Child unable to use stairs           |
| <input type="checkbox"/> Visual impairment<br>(including blindness) | <input type="checkbox"/> Developmental disabilities           |
|   | <input type="checkbox"/> Reading difficulties                 |
|   | <input type="checkbox"/> Traumatic brain injury               |
- Other medical condition(s): \_\_\_\_\_
- \_\_\_\_\_

Other health concerns: (e.g. chronic or acute health problems such as diabetes, epilepsy, hemophilia, asthma, etc.) \_\_\_\_\_

\_\_\_\_\_

Food Allergies: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Please list any other comments or concerns regarding your child that will help him/her be successful in our PSR program this year:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Student Information

## Student #4

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of birth: \_\_\_\_\_

Grade in 2018-2019 school year: \_\_\_\_\_

School Attending: \_\_\_\_\_

Has your child attended religious education classes at a different parish? Yes / No

If yes, where? Parish name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

## Medical/Physical/Educational Information

- |   |   |
|---|---|
| <input type="checkbox"/> ADD/ADHD                                   | <input type="checkbox"/> Orthopedic impairment                |
| <input type="checkbox"/> Autism                                     | <input type="checkbox"/> Speech or language impairment        |
| <input type="checkbox"/> Behavioral/Emotional disturbance           | <input type="checkbox"/> Child needs individual aide in class |
| <input type="checkbox"/> Hearing impairment<br>(including deafness) | <input type="checkbox"/> Child unable to use stairs           |
| <input type="checkbox"/> Visual impairment<br>(including blindness) | <input type="checkbox"/> Developmental disabilities           |
|   | <input type="checkbox"/> Reading difficulties                 |
|   | <input type="checkbox"/> Traumatic brain injury               |
- Other medical condition(s): \_\_\_\_\_  
\_\_\_\_\_

Other health concerns: (e.g. chronic or acute health problems such as diabetes, epilepsy, hemophilia, asthma, etc.) \_\_\_\_\_  
\_\_\_\_\_

Food Allergies: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Please list any other comments or concerns regarding your child that will help him/her be successful in our PSR program this year:

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