

Office Use Only

B/C - Y N

Pd Date _____

Check # _____

Amt. Pd _____

REGISTRATION FORM
ST. MARGARET MARY PARISH
111 S. HUBBARD ST.
ALGONQUIN, IL
847-658-7881

Class Time Options

Sunday: 2:30-4:30 PM

Or Tuesday: 7-9 PM

You may attend any class time that works out best with your schedule on a session by session basis.

Registration Fee-\$80.00

Checks payable to St. Margaret Mary YM

CONFIRMATION CLASSES 2016-2017 SCHOOL YEAR

TODAY'S DATE: _____

FAMILY NAME: _____ CANDIDATE'S NAME: (first) _____ (last) _____

MOTHER'S MAIDEN NAME: _____ (Required)

ADDRESS _____ P.O. BOX: _____

CITY: _____ ZIP CODE: _____ HOME PHONE: (____) _____
UNLISTED? Y N

EMAIL _____ Cell Phone # _____

REGISTERED AT THIS CHURCH: Y N Envelope # _____

=====PARENTS/GUARDIANS=====

RELATIONSHIP TO CHILD: _____ RELATIONSHIP TO CHILD _____

NAME: _____ NAME: _____

BUS PHONE: _____ BUS PHONE: _____

RELIGION: _____ RELIGION: _____

MARTIAL STATUS: _____ MARTIAL STATUS: _____

=====PHYSICIAN/INSURANCE INFORMATION=====

NAME OF PHYSICIAN: _____ PHONE: (____) _____

NAME OF HEALTH INSURANCE COMPANY: _____

POLICY IN NAME OF: _____

IN CASE OF MEDICAL EMERGENCY, I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN OF _____. IN THE EVENT THAT I CANNOT BE REACHED, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE ADULT STAFF OF ST. MARGARET MARY PARISH RELIGIOUS EDUCATION PROGRAM TO SECURE PROPER MEDICAL TREATMENT DEEMED NECESSARY FOR MY CHILD. I UNDERSTAND THAT I WILL BE PROMPTLY NOTIFIED IN THE EVENT OF ANY SERIOUS ACCIDENT OR ILLNESS AND PRIOR TO ANY MAJOR SURGERY, EXCEPT WHEN DELAY IN COMMUNICATION WOULD ENDANGER LIFE.

SIGNATURE OF PARENT/GUARDIAN DATE

IN EVENT OF AN EMERGENCY, IF YOU ARE UNABLE TO REACH ME, PLEASE CONTACT THE FOLLOWING:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

CONTINUED:

CANDIDATE'S NAME (Last): _____ (First): _____

BIRTH DATE: ____/____/____

GRADE ENTERING IN FALL 2016: _____ AGE: _____ SEX: _____

SCHOOL: _____

ATTENDED RELIGIOUS EDUCATION HERE BEFORE: Y N

For Confirmation: Sacramental information must be filled out completely.

We are updating our records, no information remains on file. Please include all information on Sacraments.

	DATE	PLACE SACRAMENT WAS PERFORMED	Complete Address of Baptismal Parish
BAPTISM	__/__/__	_____	_____
PENANCE	__/__/__	_____	_____
1 ST COMM	__/__/__	_____	

Baptismal Certificates are **required** for *all* Confirmation candidates.

Baptismal certificates are not transferred from Religious Ed, so if you have submitted one in the past, we do not have a copy of that, we will need a new copy.

===== **MEDICAL INFORMATION** =====

Does child named on form require any special attention regarding areas listed below? (PLEASE 'X' ALL THAT APPLY):

ALLERGIES	<u>SPECIAL LEARNING NEEDS*</u>	<u>ILLNESSES</u>
<input type="checkbox"/> Food (specify) _____	<input type="checkbox"/> Hearing limitations	<input type="checkbox"/> Asthma
<input type="checkbox"/> Medication (specify) _____	<input type="checkbox"/> Vision limitations	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bee stings	<input type="checkbox"/> Reading limitations	<input type="checkbox"/> Other
<input type="checkbox"/> Other	<input type="checkbox"/> Writing limitations	<input type="checkbox"/> Physical limitations
	<input type="checkbox"/> Speech limitations	
	<input type="checkbox"/> Attention Deficit Disorder	
	<input type="checkbox"/> Other	

*Please explain any checked above: _____

Does your child take any medications on a regular basis? YES _____ NO _____

If yes, please specify: _____

VOLUNTEER OPPORTUNITIES: (Please check any you are interested in or add your talent)

Facilitators of a Small Class _____ Chaperone for Outings _____ Drivers _____ Calling Tree _____ Prayer Network: _____

Mailer: _____ Retreat Facilitator _____ Office Help _____ Special Events Planners _____ Open Gym Chaperone _____

Service Project Planners _____ Public Relations _____ Other _____