YOUNGSTOWN CITY REGIONAL RELIGIOUS EDUCATION PROGRAM

REGISTRATION FORM

Parent Information

Father's Full Name: _____ Phone _____

Address: Street_____ City _____ Zip _____

Mother's Full Name: _____ Phone _____

Address: Street_____ City _____ Zip _____

Father's Religion: _____ Mother's Religion: _____

Father's Email: _____ Mother's Email: _____

Children's Information:

For each child, please list full first name (no nicknames) and last name if different from father's

Child: _____ Date of Birth ___/___/___ Grade _____

Church of Baptism_____ City/State _____

Child: _____ Date of Birth ___/___/___ Grade _____

Church of Baptism_____ City/State _____

Child: _____ Date of Birth ___/___/___ Grade _____

Church of Baptism_____ City/State _____

Child: _____ Date of Birth ___/___/___ Grade _____

Church of Baptism_____ City/State _____

Child: _____ Date of Birth ___/___/___ Grade _____

Church of Baptism_____ City/State _____

Baptismal Certificates

Please include a copy of the Baptismal certificate for each child who will be entering the CCD Program for the first time.

Financial Support for the CCD Program

All Catholic parishioners have a right to formal catechetical programming. Therefore, we do not charge a designated fee for our CCD students.

Please bring this completed form to the first CCD session or mail it to Sister Regina at 144 W. Wood Street, Youngstown, OH 44503.

If you have any questions, call Sister Regina at 330-744-5233 or email Sister Regina at rrogers@youngstowndiocese.org

YOUNGSTOWN CITY PARISHES
Regional Religious Education Program

EMERGENCY MEDICAL FORM

The Diocese has requested that all persons working in the Parish CCD Program have an emergency medical form on file in the CCD office. In order to help us with any emergency situation which may occur with you, I am asking you to please fill out this form and return it to Sister Regina.

Thank you for your cooperation

Child's Name_____ Birthdate _____

Home Address_____City_____ Zip _____

E-Mail_____

Cell Phone Number _____ Additional phone numbers: (i.e., home phone) _____

PARENT, RELATIVE OR NEIGHBOR TO CONTACT IF NEEDED:

1. Name _____ Phone No. _____
   Relationship: _____

2. Name _____ Phone No. _____
   Relationship: _____

Family Physician_____ Phone No. _____
Family Dentist _____ Phone No. _____
Preferred Hospital_____ Phone No. _____

No Medication will be administered without the written permission (information to be used for emergencies only).

Medicine currently used: _____

_____

Any restrictions on activity? _____

Any eating restrictions? _____

Allergies? _____

Other comments: _____

PART I. – <u>To Grant Request</u>

If we, or the authorized physician named above cannot be reached at the time of emergency, and if immediate observation or treatment is urgent, we hereby authorize and direct the program director to send you, properly accompanied, to the hospital, emergency treatment center, or physician most easily accessible.

Signature_____Date:_____

PART II. – <u>Refusal to Consent</u>

I do not give my consent for emergency treatment. In the event of illness or injury requiring emergency treatment, I wish the program director to take no action or to _____

Signature_____Date:_____