

**SACRED HEART PARISH RELIGIOUS EDUCATION PROGRAM
NEW FAMILY REGISTRATION FORM (Grades K - 5)**

FAMILY NAME: _____ **HOME PHONE** _____

ADDRESS: _____ **E-MAIL** _____

CITY _____ **ZIP** _____

REGISTERED PARISH MEMBER: Yes No

Mother's first name: _____ **Maiden:** _____

Religious Affiliation: _____

Place of Employment: _____ **Work Phone:** _____

Cell Phone _____

Father's full name: _____

Religious Affiliation: _____

Place of Employment: _____ **Work Phone:** _____

Cell Phone _____

Child lives with: _____

Child's full name: _____

Date of birth _____ **City & State:** _____

School _____ **Grade:** _____ **Age:** _____

Medical problem: _____

SACRAMENT INFORMATION:

Baptism: Yes No (Copy of Baptism Certificate required)

Church: _____ **Date of Baptism:** _____

City: _____ **State:** _____ **Zip:** _____

FIRST RECONCILIATION Yes No **FIRST COMMUNION** Yes No

EMERGENCY CONTACT: _____ **PHONE** _____

Persons who regularly or occasionally come for child at dismissal:

FEE: \$25 *one child* Check payable to **Sacred Heart Church**
\$40 *family fee*

Confidentiality notice: This document is intended for use by Sacred Heart Parish Faith Formation Program. Any dissemination, distribution or copying of this document is strictly prohibited.

DIOCESAN RELEASE FORM

Family Name: _____

*I will support the **POLICIES** and procedures of this program as specified in the handbook on the website at http://sacredheartfl.org/mini_ed_hb2.html (A copy can be requested from the office).*

*I give permission for **PICTURES** / images of my children to be used by the parish, without names or other personal information in connection with educational, liturgical, promotional activities or for any other legitimate purpose and in any media form, without any compensation now or future. I release the Diocese of Venice, a corporation sole, and its leadership, from any claims resulting from use of these images.*

I give permission for the religious education office/personnel to communicate information to my e-mail and / or text message my phone

MEDICAL AUTHORIZATION

Primary Care Physician for my children:

_____ phone _____

In case of the illness or injury of one of my children and neither parents / guardians can be reached to deal with this medical emergency, I authorize an official of Sacred Heart Parish to consent to any x-ray examination, anesthetic, medical or surgical treatment, and/or hospital care, as determined necessary and appropriate by a physician licensed in Florida. I will assume the financial responsibility for any medical treatment provided for my child.

signature of parent/guardian: _____