SACRED HEART PARISH RELIGIOUS EDUCATION

**RETURNING FAMILY RE-REGISTRATION** (Grades K - 5)

**FAMILY LAST NAME**_____ Home Phone _____

Mailing address: _____ Zip _____

E-Mail: _____

MOTHER's NAME (first)_____(maiden)_____

Cell Phone: _____Work Phone: _____

FATHER's NAME:_____

Cell Phone: _____ Work Phone: _____

CHILD's NAME AGE GRADE MEDICAL PROBLEM

_____

_____

_____

School: _____

EMERGENCY CONTACT _____PHONE _____

Persons who regularly or occasionally come for child at dismissal:

_____

*Confidentiality notice: This document is intended for use by Sacred Heart Religious Education Program. Any dissemination or distribution of this document is strictly prohibited.*

Payment is $25.00 for one child / $40.00 family fee payable to
**Sacred Heart Church**

***PLEASE NOTE:*** **If your address, home or cell phone has been changed since January 2014, please put an * beside the new one so we can change our record.**

# 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:_____