

St Matthew Parish

Religious Education Registration

1001 E Schaumburg Rd, Schaumburg, IL 60194 (847) 891-1220

Family Last Name: _____

Date: _____

Father's Name: _____

Home Phone: _____

Mother's Name: _____

Mom/Dad Work/Cell: _____

Mother's Maiden: _____

Emergency Contact: _____

Custodial Parent, if different from above _____

Email: _____

Home Address: _____

Both Parents Catholic? Y___ N___

Child	Birthdate	Sex	Grade	Session	Room	Class
-------	-----------	-----	-------	---------	------	-------

Sacrament and Date: Baptism *Catholic?* Eucharist Penance Confirmation

_____ _____
 _____ _____
 _____ _____

Special Needs: medical, learning disabilities, physical disabilities: _____

Child	Birthdate	Sex	Grade	Session	Room	Class
-------	-----------	-----	-------	---------	------	-------

Sacrament and Date: Baptism *Catholic?* Eucharist Penance Confirmation

_____ _____
 _____ _____
 _____ _____

Special Needs: medical, learning disabilities, physical disabilities: _____

Child	Birthdate	Sex	Grade	Session	Room	Class
-------	-----------	-----	-------	---------	------	-------

Sacrament and Date: Baptism *Catholic?* Eucharist Penance Confirmation

_____ _____
 _____ _____
 _____ _____

Special Needs: medical, learning disabilities, physical disabilities: _____

Child	Birthdate	Sex	Grade	Session	Room	Class
-------	-----------	-----	-------	---------	------	-------

Sacrament and Date: Baptism *Catholic?* Eucharist Penance Confirmation

_____ _____
 _____ _____
 _____ _____

Special Needs: medical, learning disabilities, physical disabilities: _____

NOTE: If any of your children were baptized outside of this parish, and you have not already supplied us with a copy of each child's baptismal record, you will need to supply a copy for our files.

Tuition due: \$ _____ Tuition Pd: \$ _____ Signature: _____

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION AUTHORIZATION FOR MEDICAL TREATMENT



Name of Student's Physician _____

Physician Phone # _____

Medical Insurance Provider _____ Policy/Insurance # _____

Student(s) First Name & Last Name	List medical allergies and/or significant medical history. Please list any medications currently taking.
1.	
2.	
3.	
4.	

Family Contact Information:

Name _____ Relationship to Student(s) _____

Home Phone # _____ Cell Phone # _____

Name _____ Relationship to Student(s) _____

Home Phone # _____ Cell Phone # _____

Emergency contact in case parent/guardian cannot be reached:

Name _____ Relationship to Student(s) _____

Home Phone # _____ Cell Phone # _____

MEDICAL RELEASE:

In the event that the undersigned cannot be reached and in the judgment of the adult on site, there is a necessity for immediate examination and/or treatment of my child, I hereby request and authorize any of the aforesaid personnel to obtain for my child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

Parent/Guardian Signature _____ Date _____