Saint Columba Catholic Church
Christian Youth Education
Initial Registration Form
(To be completed when child initially enters the CYE Program)

Student Name: _____ Gender: F / M

Address: _____
Street City Zip code

Date of Birth: _____City of Childs's Birth_____

School Attending: _____ **Grade:** _____

Telephone: _____ _____
Primary Secondary

E-mail address: _____

Father's Name: _____ Religion: _____

Mother's Name: _____ Religion: _____

Mother's Maiden Name: _____

Primary Contact: _____ _____ _____
Name Phone Email

Is your Family registered at Saint Columba Parish? ☐ **Yes /** ☐ **NO**
(if NO Church Affiliation: _____)

Sacrament(s) student has received:

	Church	Location	Date
Baptism*	_____	_____	_____
1st Penance	_____	_____	_____
1st Communion	_____	_____	_____
Confirmation	_____	_____	_____

***Baptismal Certificate Required if *not* at St. Columba please email or send a copy.**

Name of Parent(s)/Guardians(s) student is living with: _____

Registration Fee (up to 2 Children) $30.00/child
Additional Children $15.00/child

Scan QR to Pay On-line
☐ **Paid on line**

Registration Fee: $ _____
☐ **Cash** ☐ **Check #_____**

_____ _____
Signature Date

Emergency Medical Authorization Form

IF ABOVE PARENTS/GUARDIANS CANNOT BE REACHED, PLEASE CALL:

First Contact's Name _____ Home Phone _____ Work Phone _____

Address _____ Relationship _____

Second Contact's Name _____ Home Phone _____ Work Phone _____

Address _____ Relationship _____

Allergies (including foods): _____

Medical Problems: _____

_____

Taking medication: Yes _____ No _____ **List**: _____

Reason: _____

Hospital preference: _____

Physician/clinic: _____ Phone: _____

Dentist: _____ Phone: _____

In case of accident or serious illness, I request the parish to contact me or my designate. If this cannot be done, I authorize the parish to call the physician or dentist listed on this card and to follow his/her instructions. If the physician or dentist named cannot be reached, the parish may seek medical services that seem necessary. I realize the parish does not assume responsibility for the payment of medical expenses.

In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or physician permission to treat my daughter/son as necessary.

Signed: _____ **Date:** _____

OR:

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the parish authorities to take no action or to:

_____

Signature of Parent/Guardian: _____ Date: _____