**Saint Columba Catholic Church**
**Christian Youth Education**

**Returning Student Registration Form**

| Last Name | First | Middle | Grade |
|---|---|---|---|
| Last Name | First | Middle | Grade |
| Last Name | First | Middle | Grade |
| Last Name | First | Middle | Grade |
| Last Name | First | Middle | Grade |
| Last Name | First | Middle | Grade |

## Changes in Contact information: ☐YES / ☐NO

If **YES,** please Complete Page 2 *for each child with changes*

## Changes in Emergency Medical Information: ☐ YES / ☐ NO

If **YES,** please Complete Page 3 *for each child with changes*

**Registration Fee (up to 2 Children) $30.00/child**
**Registration Fee (Additional Children) $15.00/child**
**(scan QR Code Below to pay on line)**

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

**Signed: _____ Date: _____**

## Changes in Contact Information Year _____

_____ _____

**Last Name** **First** **Middle** **Grade**

Address _____ Home Phone _____

Zip Code

E-mail address: _____

Mother's/ Guardian's Name: _____ Work Phone _____

Father's/ Guardian's Name: _____ Work Phone _____

**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 _____

# Changes in Emergency Medical Information Year _____

_____ _____

**Last Name** **First** **Middle** **Grade**

**Allergies (including foods):** _____

**Medical Problems:** _____

**Taking medication**: ☐ Yes ☐ No

**List Medications:** _____

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: _____