SAINTS PETER AND PAUL CCD

NEW STUDENT REGISTRATION FORM

Pre-School

2015 – 2016 Session

A Parish Census form must be completed front and back, if one is presently not on file, and turned in with this registration. You must present an original baptismal certificate, church seal affixed, at the time of registration. NO copies will be accepted. A copy of the original will be made and returned to you. Children must be 3 years old by September 30. All pre-school aged children must be potty-trained.

Fill in Completely and Please Print Clearly.

CHILD'S FULL NAME: ____________________ BIRTH DATE: ___/___/___ SEX: F M

MAILING ADDRESS: ____________________ STREET ADDRESS: ____________________

CITY/STATE: ____________________ ZIP CODE: __________ PHONE: __________

CURRENT SCHOOL: ____________________ GRADE: __________

RESIDES WITH: ____________________ RELATIONSHIP: __________

FATHER'S FULL NAME: ____________________

HOME ADDRESS & PHONE (IF DIFFERENT): ____________________

MOTHER'S FULL MAIDEN NAME: ____________________

HOME ADDRESS & PHONE (IF DIFFERENT): ____________________

E-MAIL ADDRESS: ____________________

SACRAMENTAL INFORMATION: **Note**- all dates require a month, day and year.

Circle: **Y** if the sacrament was received but the date is unknown, **N** if the sacrament has not been received, or **H** if the sacrament was received here at Sts. Peter and Paul

BAPTISM: Y N H - Church ____________________ City/State: __________ Date: ___/___/___

The above-named child is free of any contagious diseases, and is in good physical condition, and able to participate in regular activities. I, the undersigned parent/guardian, authorize the CCD staff to:

1) Care for my child during the time he/she is under their supervision at school.
2) Secure emergency medical care in the event that I cannot be reached.

Signature of Parent or Legal Guardian: ____________________ Date: ___/___/___

PLEASE GIVE THE NAME AND PHONE NUMBER OF TWO PEOPLE WE MAY CONTACT IN CASE OF AN EMERGENCY:

1. ____________________ Phone: __________ Relationship: __________
2. ____________________ Phone: __________ Relationship: __________

Does your child have any learning or medical disabilities of which we should be aware? ____________________

Please circle any or all that apply:

Allergies (including drug) | Attention Deficit | Dyslexia | Hyperactivity
Asthma | Diabetes | Hearing or Speech Impairment | Vision Impairment

Other: ____________________

Is he/she on any medication for this condition? N Y ____________________

CHILD'S PHYSICIAN: ____________________ PHONE: __________

This space is for office use only: ID Number __________ Book Fee: $25.00

Amount Paid: __________ by Cash _______ or Check # _______Balance Due _________Form entered: _____________