CHURCH OF ST. ISABELLA

PARISH SCHOOL of RELIGION REGISTRATION FORM 2019-2020

Classes begin Sunday, September 22, 2019

PSR classes are held Sundays 10:15am - 11:25am at St. Isabella's School.

Child(ren)'s LAST Name: _____ **DATE:**_____

Child's FIRST Name	Grade in Fall 2019	School attending	Is child baptized Catholic?	Has child received 1st Communion?	Has child received 1st Reconciliation?

If your child is preparing for First Communion or Confirmation this year, please attach a copy of baptismal certificate with registration (unless baptized at St. Isabella's or St. Vincent's)

Please indicate **Allergies or Medical Conditions**:

Student Name	Allergy/Condition

Parental/Guardian Info: Child(ren) lives with: mom & dad__ mom___ dad___ guardian__

Parent / Guardian #1	Parent / Guardian #2
Name:	Name:
Address:	Address:
Home Tel:	Home Tel:
CELL:	CELL:
EMAIL:	EMAIL:
Religion:	Religion:

Our program needs lots of help! Would you consider being a ( ) Classroom assistant ( ) Assistant Teacher ( ) Service event helper ( ) Paperwork helper ( ) Music helper ( ) Art helper ( ) Lector with your child at Mass ( ) Other_____

Permission & Emergency Information (WE NEED TWO CONTACTS OTHER THAN PARENTS):
The adults named below have permission to pick up my child from PSR and are also our emergency contacts:

Name	Relationship	Home Phone	Cell Phone
1.			
2.			

In case of serious accident or illness, PSR authorities will act according to their best judgment for the welfare of your child. Emergency services in the area may be utilized. I (we) the undersigned parent(s) or legal guardian(s) of _____ minor(s), do hereby authorize and consent to any emergency medical treatment rendered under the general or special supervision of any member of the medical staff/emergency room staff licensed under provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment of the patient, but that emergency treatment will not be withheld if the undersigned cannot be reached.

If a parent or guardian cannot be reached, I wish my child taken to the nearest emergency hospital. Yes □ No □ Preferred Hospital_____

Physician Name	**Telephone**	**Dentist Name**	**Telephone**
Health Insurance		**Policy/Group Number**	

Parent/Guardian #1 **Printed Name** _____
(**SIGNATURE REQUIRED)**: X_____ Date_____

PARENT/GUARDIAN #2 **Printed Name** _____
(**SIGNATURE REQUIRED):** X_____ Date_____

Tuition	
1 child	$ 110
2 children	$ 220
3 or more children	$ 90 per child

****Registration must be received before child(ren) attend first class.**

You must register with the parish in order to participate in the PSR program.
Parish registration forms are found in our weekly bulletin or on our church website.

I wish to pay by Check _____ Cash _____ Visa _____ Mastercard _____
Card # _____Expiration date _____
Amount to be charged $ _____

Thank you! Please drop this form in the rectory mail slot.
See you on September 22nd at the **Parent Meeting** during our first day of classes. You can also check our website (stisabellasparish.org) for news & info.
Any questions, contact Lyn Gatti (lyn@stisabellasparish.org) 415-479-1560 x12