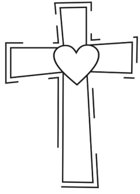

ST. ISABELLA'S PARISH SCHOOL OF RELIGION
2016-2017 REGISTRATION FORM
(Classes begin Sunday, Sept 25, 2016)

PSR classes are held Sundays 10:15am - 11:25am

**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.

FAMILY NAME: ____________________________ DATE:_________

PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
NAME:	NAME:
HOME ADDRESS:	HOME ADDRESS:
HOME PHONE:	HOME PHONE:
CELL PHONE:	CELL PHONE:
EMAIL:	EMAIL:
RELIGION:	RELIGION:

PLEASE MARK SACRAMENTS **ALREADY RECEIVED**:

STUDENT NAME	GRADE	SCHOOL	BAPTISM	FIRST RECONCILIATION	FIRST HOLY COMMUNION	CONFIRMATION

PLEASE INDICATE ALLERGIES OR MEDICAL CONDITIONS:

STUDENT NAME	ALLERGY/CONDITION

Is your child preparing for a sacrament? If so, please attach a copy of his/her Baptismal certificate (unless baptized here at St. Isabella's or St Vincent's.)

Can we use your child's image on the PSR page of our church's website? Yes( ) No( )

Can we add your 6th-8th grader on our emails about classes & events?

Student name__________________________ Email: ________________________

Student name__________________________ Email: ________________________

Please participate! Would you like to be a ( ) Lector with your child at Mass

( ) Classroom assistant ( )Assistant Teacher ( ) Service project assist

Other_____________________

Permission & Emergency Information: 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 NO.	

PARENT/GUARDIAN #1 **(SIGNATURE REQUIRED): Printed Name** ________________________

X____ Date________________________

PARENT/GUARDIAN #2 **(SIGNATURE REQUIRED): Printed Name** _______________________

X____ Date________________________

TUITION	
1 child per family	$ 95
2 children per family	$145
3 or more children per family	$170

PAYMENT: Please complete registration form, make checks payable to St. Isabella's PSR, & drop off the Rectory mail slot (1 Trinity Way, San Rafael) or

VISA/MASTERCARD # __________________________ EXP _____

TOTAL AMOUNT TO BE CHARGED: $________

Thank you and welcome to our program! Check our website for news & info.

Any questions, contact Lyn Gatti (lyn@stisabellasparish.org) 415-479-1560 x13