

**St. Jude Parish School of Religion  
Registration Form 2005-2006 School Year**

Student's Baptismal Name:

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Name the student wishes to be called: \_\_\_\_\_ circle one Male / Female

Student's Address \_\_\_\_\_ zip code \_\_\_\_\_

Student's Phone \_\_\_\_\_ Birth date \_\_\_\_\_ PSR Grade level \_\_\_\_\_

Public School Attending in 2005-2006 \_\_\_\_\_ Dayschool Grade \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's Address if different \_\_\_\_\_ stepfather \_\_\_\_\_

Mother's evening phone number \_\_\_\_\_ Mother's cell phone \_\_\_\_\_

Father's Address if different \_\_\_\_\_ stepmother \_\_\_\_\_

Father's evening phone number \_\_\_\_\_ Father's cell phone \_\_\_\_\_

Parish where family is registered: \_\_\_\_\_

**If student is new to the program** please list the following dates and churches for completed sacraments. A copy of the Baptismal certificate is required for all new students prior to the start of classes.

Baptism \_\_\_\_\_

First Communion \_\_\_\_\_

Confirmation \_\_\_\_\_

Please list any information regarding you child that a teacher should know (e.g. medical alert, special educational needs) \_\_\_\_\_

\_\_\_\_\_ I am interested in being an assistant in a PSR classroom. (fee discount available)

Name: \_\_\_\_\_

\_\_\_\_\_ I am interested in being a room mom for my child's PSR classroom.

Main duties involve reminder phone calls.

Name: \_\_\_\_\_

As parents and primary educators, we are interested in our child's religious education. We pledge our support to the PSR program regarding attendance, discipline and assignments. We will communicate to our child the need to accept PSR as a part of their education.

Parent Signature: \_\_\_\_\_

The following release form will enable my child to participate in all scheduled PSR and sacramental preparation activities as identified in the PSR Handbook and as amended in the PSR newsletter.

**ARCHDIOCESE OF CINCINNATI  
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY**

1. I, the lawful parent or guardian of \_\_\_\_\_ (the "child"), give permission for my child to participate in the activity described above and release from all liability and indemnify the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity.

2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

3a. I appoint the Archbishop or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the child.

(ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.

4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Parent Signature \_\_\_\_\_ date \_\_\_\_\_

Printed Name: \_\_\_\_\_

Emergency Medical Preferences –

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Children's Hospital Emergency Room # is 636-4293

Emergency Contact if mother or father cannot be reached

Name/Relationship \_\_\_\_\_ evening phone number \_\_\_\_\_

Facts concerning the child's medical history including chronic conditions, allergies, medications being taken and any physical impairments to which a physician should be alerted:

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Fees: \$70 for each child prior to May 31<sup>st</sup>; \$90 for each child after May 31<sup>st</sup>

Make checks payable to St. Jude Church    Return forms to PSR class or Church office