

**St. Elizabeth Parish School of Religion Registration Form  
School Year 2017-2018 Tuition Payment - \$45.00**

**Child's Last Name** \_\_\_\_\_

**Child's First Name** \_\_\_\_\_

**Home Address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Child's Grade** \_\_\_\_\_ **School** \_\_\_\_\_

**Birthplace** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Age** \_\_\_\_\_

**With Whom Does The Child Live?** **Mother** \_\_\_\_\_ **Father** \_\_\_\_\_ **Both** \_\_\_\_\_

**Contact Person's Name** \_\_\_\_\_

**Home Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone Number** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Work Phone Number** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**In Case of Emergency whom should we call ?** \_\_\_\_\_

**Best number to call in case of emergency** \_\_\_\_\_

**Mother's First Name** \_\_\_\_\_ **Maiden Name** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Father's First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

## Sacramental Information

**Baptism Date** \_\_\_\_\_ **Parish** \_\_\_\_\_

**City** \_\_\_\_\_ **Country** \_\_\_\_\_

**First Penance Date** \_\_\_\_\_ **Parish** \_\_\_\_\_

**First Holy Communion Date** \_\_\_\_\_ **Parish** \_\_\_\_\_

## Medical Information

**Allergies** \_\_\_\_\_

**Asthma** Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes, Does student need an inhaler with them during class?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes, Does student know how to use inhaler on his/her own?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**Does student have any other medical problems that we should be made aware of?** \_\_\_\_\_

**Any other concerns we should know about?** \_\_\_\_\_

**Any learning disabilities?** \_\_\_\_\_

**Signature of Parent or Guardian** \_\_\_\_\_

**Dated** \_\_\_\_\_

**St. Elizabeth Parish Emergency Form**  
**Please Print Information**

\_\_\_\_\_  
Child's Last Name                      Child's First Name                      Grade

\_\_\_\_\_  
Home Address                      Home Phone Number                      Date of Birth

Person responsible for making child's medical decisions  
Mother \_\_\_\_\_ Father \_\_\_\_\_ Both \_\_\_\_\_  
Other relative \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Name of person responsible for child's medical decisions Whom We Should Contact  
(if both parents responsible please list both parent's names)

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

In the event of apparent serious illness or accident, when I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence, and will inform that their names have been used on this card.. Please do not list your name in space below. It must be Some One Nearby who can be reached quickly.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Relation to Child \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

In case of minor injury, I authorize that a person qualified to administer First-aid  
In case of an accident may we contact your Family Doctor or Dentist? \_\_\_\_\_ Yes \_\_\_\_\_ No

Family Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

**Authorization to Consent to Emergency Medical Care and Waiver & Release Form**

I/We \_\_\_\_\_, the undersigned, are the parent(s) having legal custody or the person having legal custody or the legal guardian of \_\_\_\_\_, who was born on \_\_\_\_\_.

I/We hereby authorize the administration of St. Elizabeth Religious Education Program where (Child) \_\_\_\_\_ is enrolled to consent to, and agree to pay for, on my/our behalf any emergency medical, dental, surgical, or hospital care treatment, or diagnosis to be rendered to or for (child's name) \_\_\_\_\_ under the general or special supervision or a physician/surgeon or dentist pursuant to Section 1317 of the Health and Safety Code of California . It is expressly understood and agreed that an "emergency" shall be determined at the discretion of the administration of St. Elizabeth Parish. If the undersigned has left an emergency number on file at St. Elizabeth Religious Education Program reasonable attempts will normally first be made to contact undersigned or his/her designee at such number(s) prior to contacting an emergency treatment organization.

The following information will aid in safe/immediate care by medical personnel:

Date of last tetanus immunization: \_\_\_\_\_

Known allergies to medication: \_\_\_\_\_

I/We understand that St. Elizabeth Parish is not legally obligated to make the above Referenced consents or medical care. Therefore, in consideration for the above referenced arrangements, the undersigned hereby agrees to release, discharge, indemnify and hold harmless the Archdiocese of San Francisco, its constituent organizations, including, but not limited to St. Elizabeth Parish and their officers, agents, employees, from any and all claims for personal injuries, property damage, or indebtedness for medical treatment expenses that I/We or my/our child may suffer as a result of this arrangement whether or not such injuries, damage, or indebtedness are caused by the negligence (whether active or passive) of any of the entities or individuals named or described above.

Dated: \_\_\_\_\_

Signature of Parent(s) or Guardian

\_\_\_\_\_  
\_\_\_\_\_

**St. Elizabeth Religious Education Program  
Earthquake Emergency Form  
School year 2017-2018**

**In the event of an earthquake or similar disaster, I hereby authorize the administration or faculty of St. Elizabeth Religious Education Program to release my child/children to the following person(s) if I am not able to come for them myself.**

**Child's Name** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Siblings presently attending ST. Elizabeth Religious Education Program**

\_\_\_\_\_ **Grade** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Grade** \_\_\_\_\_

<b>Person(s) Authorized To Take Child</b>	<b>Address/Phone</b>	<b>Work/Cell Phone</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**My child need to take medication on a regular basis. Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If Yes, have you provided school with emergency supply? Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**Does your child have an allergy to any medication? Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes, what medication?** \_\_\_\_\_

**I also give my permission for any immediate first aid or medical attention to be given to my child if it is deemed advisable by the administration/faculty of St. Elizabeth Religious Education Program in the event of a disaster.  
This includes emergency release to paramedics and/or ambulance for hospital attention.**

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Administration Use Only (please do not write below this line)**  
**Date;** \_\_\_\_\_ **Time:** \_\_\_\_\_ **The above child was released to:** \_\_\_\_\_

**Signature of authorized person:** \_\_\_\_\_

**First Aid Administered: Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
**If yes by whom** \_\_\_\_\_

**ST. ELIZABETH CHURCH  
RELIGIOUS EDUCATION PROGRAM  
449 HOLYOKE STREET  
SAN FRANCISCO, CA 94134  
415-468-0820**

**WAIVER AND RELEASE FORM  
2017-2018**

I hereby give my consent for any photograph or video tape taken of my child can be used by the St. Elizabeth Religious Education Program.

Further, I hereby waive any and all rights, to or compensation for any photograph, video, tapes, motion pictures, recordings, or any other record of any and all events or activities which may be made by the Archdiocese/Parish/Agency and affiliate organizations.

Child Name: \_\_\_\_\_  
(Please Print)

Signature of Father/guardian:

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Signature of Mother/guardian:

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Date: \_\_\_\_\_

If your child is allowed to walk home alone, please fill out this form.

If you do NOT allow your child to walk home, DO NOT fill out this form.

I give permission to allow my child/children to walk home unsupervised after St. Elizabeth parish religious education program.

Child's/Children's Name \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_