

Preschool- 8th Grade

FAMILY INFORMATION	
Are you a registered parishioner at St. Martin? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, where are you registered?	

Mother's Name: (Include maiden name)	Are you a Catholic? Yes <input type="checkbox"/> No <input type="checkbox"/>
Mother's Mailing Address:	Home Phone:
City, State, Zip:	Work Phone:
Email address:	Cell Phone:

Father's Name: (Include maiden name)	Are you a Catholic? Yes <input type="checkbox"/> No <input type="checkbox"/>
Mother's Mailing Address:	Home Phone:
City, State, Zip:	Work Phone:
Email address:	Cell Phone:

Guardian's Name: (Include maiden name)	Are you a Catholic? Yes <input type="checkbox"/> No <input type="checkbox"/>
Mother's Mailing Address:	Home Phone:
City, State, Zip:	Work Phone:
Email address:	Cell Phone:

STUDENT INFORMATION	
Name:	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
Date of Birth: Grade:	School Attending:
Baptized? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Church:	City, State
First Communion? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Church:	City, State
List any chronic health conditions, allergies, educational behavioral needs:	

STUDENT INFORMATION	
Name:	Gender: <input type="checkbox"/> male <input type="checkbox"/> female
Date of Birth: Grade:	School Attending:
Baptized? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Church:	City, State
First Communion? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: Church:	City, State
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List any chronic health conditions, allergies, educational behavioral needs:		

PARENTS/ GUARDIAN AGREEMENT
<p>I understand that I, as parent or legal guardian of the child(ren) listed above, am required to read the 2017-2018 Polices provided by the Faith Formation program at St. Martin of Tours Parish. I understand and agree to abide by the guidelines, rules and regulations set forth in this document. I understand that my child (ren) need(s) to observe the basic rules of conduct, and adhere to the rules stated in the document. I understand that failure to comply with the family policies could bring about disciplinary actions including. In extreme cases, dismissal of my child from the catechetical program. I understand that I am responsible for sharing the rules, regulations and other important information in this document with my child.</p> <p>Signature: _____ Date: _____ Relationship to child: _____</p>

PICK UP AUTHORIZATION
<p>We encourage all parents to come into the Parish Hall when dropping off or picking up your children. If your child is in the 4th grade or below, It is mandatory that someone come into the Parish Hall to pick up your child. If a sibling will pick up your child, they must be in the 5th grade or above.</p> <p>Please list all who have permission to pick up your child (name and relationship to child)</p>

MEDICAL RELEASE
<p>As a parent and or guardian, I do herewith authorize the treatment of my child (ren) by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me first or the emergency contact person listed below.</p> <p>Name of Minor (s) _____</p> <p>1st Emergency Contact Name: _____ Relationship: _____ Home Phone: _____ Cell Phone: _____</p> <p>2nd Emergency Contact Name: _____ Relationship: _____ Home Phone: _____ Cell Phone: _____</p> <p>This releases form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence and only after all efforts have been made to reach me or the emergency contact person (s) listed.</p> <p>_____ Date _____ Parent's or Guardian's Signature</p>

MEDICAL INFORMATION FORM

This Medical Information Form should be completed annually. It is the responsibility of the parent/guardian to inform the school or parish of any changes in the child's medical condition during the year.

Participant: _____

Parent/ Guardian: _____ Phone: _____

In the event of an emergency, if you are unable to reach me at the above number, contact:
Emergency contact name (please print): _____

Relationship to participant: _____

Cell Phone: _____ Other Phone: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. YES NO

Other Medical Treatment: In the event it comes to the attention of the Parish/school/institution, its officers, directors and agents, and the Archdiocese of Mobile, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called. YES NO

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

YES NO

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

YES NO

Specific Medical Information: The school, parish will take reasonable care to see that the following information will be held in confidence:

Medications: My child is taking medication at present. My child will bring all such medication necessary and such medication will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

Allergic reactions (medications, foods, plants, insects, etc): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

MEDICAL INFORMATION FORM

(Continued)

Does child have a medically prescribed diet? _____

If yes, what is it? _____

Does child have any physical or other limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, flu, etc.? YES NO

If yes, list date and disease or condition: _____

Additional special medical conditions of my child: _____

Thereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Parent/Guardian Signature _____ Date: _____