

St. John XXIII Catholic Community Registration for Religious Formation
"3rd Grade / RECONCILIATION / EUCHARIST"

CHOOSE ONE SESSION BELOW:

_____ Sunday 10:30 to 12:00pm **OR** _____ Wednesday 5:45 to 7:15pm

TODAY'S DATE _____

IS FAMILY REGISTERED AT ST. JOHN XXIII CHURCH? YES: _____ OTHER: _____

NOTE: Please provide a copy of your child's Baptismal certificate with this completed form if your child was Baptized outside of John XXIII Catholic Community! Sacraments cannot be celebrated if a copy is not turned in!

STUDENT: LAST NAME _____ MALE ___ FEMALE ___

(1) FIRST NAME _____ M.I. _____

DATE of BIRTH _____ / _____ / _____

GRADE LEVEL _____ SCHOOL _____

Please check Sacraments received: Baptism ___ Reconciliation ___ Eucharist ___ Confirmation ___

Does your child have any physical, mental, or emotional concerns that we need to be aware of?

If yes, please explain: _____

Is your child diabetic? Yes No Suffer from seizures? Yes No

Is your child allergic to any foods or medicines? No Yes

If yes, list them. _____

Does your child have difficulties with any of the following? (If so, please explain)

Asthma ADD ADHD Autism Hyperactivity Eyesight

Reading Writing Speaking Hearing Other

Please explain: _____

Please list any medications your child is taking that we should be aware of: _____

STUDENT: LAST NAME _____ MALE ___ FEMALE ___

(2) FIRST NAME _____ M.I. _____

DATE of BIRTH _____ / _____ / _____

GRADE LEVEL _____ SCHOOL _____

Please check Sacraments received: Baptism ___ Reconciliation ___ Eucharist ___ Confirmation ___

Does your child have any physical, mental, or emotional concerns that we need to be aware of?

If yes, please explain: _____

Is your child diabetic? Yes No Suffer from seizures? Yes No

Is your child allergic to any foods or medicines? No Yes

If yes, list them. _____

Does your child have difficulties with any of the following? (If so, please explain)

Asthma ADD ADHD Autism Hyperactivity Eyesight

Reading Writing Speaking Hearing Other

Please explain: _____

Please list any medications your child is taking that we should be aware of: _____

(CONTACT INFORMATION & RELEASE FORM ON THE BACK ...PLEASE COMPLETE & TURN IN)

IF YOUR CHILD HAS NOT BEEN BAPTIZED PLEASE FILL OUT INFORMATION BELOW

CHILDS DATE OF BIRTH _____

CHILDS FULL NAME _____

CITY AND STATE OF BIRTH _____

FATHER'S NAME _____

MOTHER'S MAIDEN NAME: _____

CONCTACT INFORMATION

HOME PHONE # _____

HOME ADDRESS _____

CITY _____ ZIP _____

EMAIL ADDRESS _____

PARENT(S) FIRST NAMES: _____

CELL#(s) _____ WORK #(s) _____

NOTE IF LAST NAME IS DIFFERENT THAN CHILD'S LAST NAME: _____

RELIGION OF PARENT (S): _____

EMERGENCY CONTACT INFORMATION

In an emergency, if unable to reach the parent (s), please contact:

Name: _____ **Relationship:** _____ **Phone #** _____

PHOTO / VIDEO RELEASE

I hereby give permission for my child (ren) to be photographed or videotaped at John XXIII Catholic Community for the year registered in Religious Formation. I realize the *photo/video* may be published in the bulletin or other parish publications. The photo/video may be used for informational, educational or promotional purposes regarding our Religious Formation program.

Parent Signature: _____ **Date:** _____

I have read and completed the above information and certify that I have disclosed all medical information regarding my child (ren).

Parent Signature: _____ Date: _____

OFFICE USE ONLY

Full Name:

Father's Name:

Mother's Maiden Name:

Date of Birth:

Location:

Date of Baptism:

Location:

“additional student page”

STUDENT: LAST NAME _____ MALE ___ FEMALE ___
(3) FIRST NAME _____ M.I. _____
DATE of BIRTH _____ / _____ / _____
GRADE LEVEL _____ SCHOOL _____

Please check Sacraments received: Baptism ___ Reconciliation ___ Eucharist ___ Confirmation ___

Does your child have any physical, mental, or emotional concerns that we need to be aware of?

If yes, please explain: _____

Is your child diabetic? Yes No Suffer from seizures? Yes No

Is your child allergic to any foods or medicines? No Yes

If yes, list them. _____

Does your child have difficulties with any of the following? (If so, please explain)

Asthma ADD ADHD Autism Hyperactivity Eyesight

Reading Writing Speaking Hearing Other

Please explain: _____

Please list any medications your child is taking that we should be aware of: _____

STUDENT: LAST NAME _____ MALE ___ FEMALE ___
(4) FIRST NAME _____ M.I. _____
DATE of BIRTH _____ / _____ / _____
GRADE LEVEL _____ SCHOOL _____

Please check Sacraments received: Baptism ___ Reconciliation ___ Eucharist ___ Confirmation ___

Does your child have any physical, mental, or emotional concerns that we need to be aware of?

If yes, please explain: _____

Is your child diabetic? Yes No Suffer from seizures? Yes No

Is your child allergic to any foods or medicines? No Yes

If yes, list them. _____

Does your child have difficulties with any of the following? (If so, please explain)

Asthma ADD ADHD Autism Hyperactivity Eyesight

Reading Writing Speaking Hearing Other

Please explain: _____

Please list any medications your child is taking that we should be aware of: _____