

St. John XXIII Catholic Community Registration for Religious Formation

Kindergarten through Mid-School

"FAMILY RELIGIOUS FORMATION"

(This session will ONLY meet the FIRST SUNDAY of the MONTH from 12:45 pm to 3:00pm)

Please see flyer for more information.

TODAY'S DATE _____

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

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: _____

LIST ALL OTHER FAMILY MEMBERS WHO WILL ATTEND THIS SESSION

NAME _____ Relation to child(ren) _____
NAME _____ Relation to child(ren) _____
NAME _____ Relation to child(ren) _____
NAME _____ Relation to child(ren) _____

CONTACT 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): _____

PHOTO / VIDEO RELEASE

I hereby give permission for my family 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). I have also read the informational flyer and agree that by choosing this session my family will take an active part in my children's religious formation journey every week.

Parent Signature: _____ Date: _____

At John XXIII, our parishioners support Religious Formation through their Sunday contributions. Because of this, if you are a registered and contributing member of John XXIII, there is no registration fee. **If you do not want to be registered at John XXIII, there is a \$45.00 fee per person. This is to cover textbooks and supplies. If this is a hardship on the family, please speak to the Director.**

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: _____