

**2017 - 2018**  
**St. Simon Stock Parish**  
**Religious Education Registration**  
 178 White Horse Pike, Berlin, NJ 08009

**Family Last Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_  
**Mother's Name:** \_\_\_\_\_ **Mom/Dad Work/Cell:** \_\_\_\_\_  
**Mother's Maiden:** \_\_\_\_\_ **Emergency Contact:** \_\_\_\_\_

Custodial Parent, if different from above: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Address: \_\_\_\_\_ Both Parents Catholic? Y \_\_\_ N \_\_\_

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Child	Birthdate	Sex	Grade	Session	Room	Class
_____	_____	_____	_____	_____	_____	_____

**Sacrament and Date:** Baptism Catholic? Eucharist Penance Confirmation  
 \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

Special Needs: Medical, Learning Disabilities, Physical Disabilities: \_\_\_\_\_

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Child	Birthdate	Sex	Grade	Session	Room	Class
_____	_____	_____	_____	_____	_____	_____

**Sacrament and Date:** Baptism Catholic? Eucharist Penance Confirmation  
 \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

Special Needs: Medical, Learning Disabilities, Physical Disabilities: \_\_\_\_\_

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**Sacrament and Date:** Baptism Catholic? Eucharist Penance Confirmation  
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Special Needs: Medical, Learning Disabilities, Physical Disabilities: \_\_\_\_\_

NOTE: If any of your children were baptized outside of this parish, and you have not already supplied us with a copy of each child's baptismal record, you will need to supply a copy for our files.

**Tuition Due: \$** \_\_\_\_\_ **Tuition Pd: \$** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Emergency Medical Release**

To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under PREP authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number)  
or \_\_\_\_\_ (other parent or guardian)

have been unsuccessful, I hereby give my consent for:

- (1) the administration of any treatment deemed necessary by  
Dr. \_\_\_\_\_ (preferred physician) or
- (2) Dr. \_\_\_\_\_ (preferred dentist), or in the event the designated  
preferred practitioner is not available, by another licensed physician or dentist; and
- (3) transfer of the child to \_\_\_\_\_ (preferred hospital) or any hospital  
reasonably accessible.

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This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: (if none, please indicate "none").

Child Name \_\_\_\_\_

Child Name \_\_\_\_\_

Child Name \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent/Guardian

**Refusal to Consent**

(Do not complete if you completed top portion)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treat, I wish the PREP authorities to take no action or to:

\_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent/Guardian

**I give permission for Photos to be taken & shown during the year:**

Parents Signature \_\_\_\_\_