

OUR LADY OF MT. CARMEL

CCD REGISTRATION

Father: _____
First Name MI Last Name

Street City/State Zip Code

Home Phone Number Work Phone Number

email address

Mother: _____
First Name MI Last Name Maiden Name
(if different) _____
Street City/State Zip Code

Home Phone Number Work Phone Number

email address

Registered Member of the Parish? ___ Yes ___ No

******Donation: \$_____ (\$20 Per Child/\$50 Cap Per Family)**
- Scholarships available -

Student/s – note: If student is new to program, please complete next page also

Name _____ CCD Grade _____
First Name Last Name (in fall)

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First Name Last Name (in fall)

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First Name Last Name (in fall)

Name _____ CCD Grade _____
First Name Last Name (in fall)

Name _____ CCD Grade _____
First Name Last Name (in fall)

Name _____ CCD Grade _____
First Name Last Name (in fall)

Please fill out for students new to the program:

Name _____ CCD Grade _____
First Name Last Name (in fall)

Date of Birth _____

Sacraments Received: Baptism _____ Eucharist _____ Reconciliation _____

Place of Baptism _____
Church City/Town/State

Child lives with: Both Parents _____ Father _____ Mother _____ Other _____

If other please specify _____
Name/Address/Phone Number

Special Needs _____

Name _____ CCD Grade _____
First Name Last Name (in fall)

Date of Birth _____

Sacraments Received: Baptism _____ Eucharist _____ Reconciliation _____

Place of Baptism _____
Church City/Town/State

Child lives with: Both Parents _____ Father _____ Mother _____ Other _____

If other please specify _____
Name/Address/Phone Number

Special Needs _____

Name _____ CCD Grade _____
First Name Last Name (in fall)

Date of Birth _____

Sacraments Received: Baptism _____ Eucharist _____ Reconciliation _____

Place of Baptism _____
Church City/Town/State

Child lives with: Both Parents _____ Father _____ Mother _____ Other _____

If other please specify _____
Name/Address/Phone Number

Special Needs _____

Do any of the children who are enrolling have a physical or learning difficulty? Yes () No ()
If yes, please give the name of the child/children and how we can help:

MEDICAL INFORMATION/MEDICAL RELEASE

Name	Allergies (food, medication etc)	Medication/dosage	Date of last Tetanus shot
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You should be aware of these medical conditions for my son/daughter:

NOTE: No medications of any kind can be given to students during Religious Ed class. Asthma medication can be taken by the student as needed. If the student has an Epi-pen, please notify his/her teachers and instruct them in its use.

Release Statement:

In the event of a medical emergency, I give permission for my son/daughter to receive medical treatment for injury or illness, in accordance with standard medical practice by licensed medical personnel, when It is not practical to obtain the consent of the undersigned. Permission is also granted to treat minor injury on a first aid basis. Further, I agree to accept any and all financial responsibility as a result of scheduling such treatment.

Parent/Guardian Signature _____ Date _____

Insurance Carrier _____ Name of Policy Carrier _____

Policy # _____