

Tuition: \$30.00 per student  
(No more than \$70.00 per family)

GRADE \_\_\_\_\_

## *St. Patrick Parish Faith Formation 2009 - 2010*

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST)

Home Phone \_\_\_\_\_ Birthplace \_\_\_\_\_  
(CITY/STATE)

Student Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

E-mail (Most often accessed by an adult): \_\_\_\_\_

Student lives with \_\_\_ Father \_\_\_ Mother \_\_\_ Guardian

Guardian Name \_\_\_\_\_

Father's Name \_\_\_\_\_ Religion \_\_\_\_\_

Father's Address (if different than student) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Business/Cell \_\_\_\_\_

Mother's Name \_\_\_\_\_ Religion \_\_\_\_\_  
(FIRST) (MAIDEN) (LAST)

Mother's Address (if different than student) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Business/Cell \_\_\_\_\_

### **BAPTISMAL INFORMATION - Baptismal Certificate Required**

Church of Baptism/City \_\_\_\_\_

Date of Baptism \_\_\_\_\_

\_\_\_\_ Student is not baptized

\_\_\_\_ Student baptized in other Christian Tradition, i.e. Methodist, Baptist, \_\_\_\_\_

\_\_\_\_ Student has celebrated the following Sacraments:

\_\_\_\_ Eucharist (copy on file Y N) \_\_\_\_ Reconciliation (copy on file Y N) \_\_\_\_ Confirmation (copy on file Y N)

#### **(For Office Use ONLY)**

Copy of Baptismal Certificate in student's file \_\_\_\_\_

Tuition paid \_\_\_\_\_ Check # \_\_\_\_\_

Date/Initial \_\_\_\_\_

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Student Name:                      Last    First

**IN AN EMERGENCY, PLEASE CONTACT IN THIS ORDER:**

1. \_\_\_\_\_  
Telephone(s)                      Name                      PARENT (S)

2. \_\_\_\_\_  
Telephone(s)                      Name                      Relationship to student

3. \_\_\_\_\_  
Telephone(s)                      Name                      Relationship to student

Student has responsible party's permission to be picked-up by:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Student Health Issues, Allergies, Special Needs (Please be specific)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Physician: \_\_\_\_\_  
Name    Telephone

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_

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