SACRED HEART CHURCH

PARISH SCHOOL OF RELIGION REGISTRATION

2024-2025

STUDENT INFORMATION (*Complete all information*).

Student's Full Baptismal Name:

_____

Birth Date ____/____/____ Birth City/State: _____

Circle one: Male /Female

Student's Address:

_____

Student lives with (*Circle one*): Both Parents, Mother, Father, Other Guardian

MOTHER'S CONTACT INFORMATION

Mother's Full Name (Please include maiden name.)

_____

Cell # _____ E-mail Address _____

Address if different for child _____

Stepmother's Name _____ Cell # _____

FATHER'S CONTACT INFORMATION

Father's Full Name_____

Cell Number: _____ Email Address _____

Address (If different from child.) _____

Stepfather's Name _____ Cell # _____

GUARDIAN'S CONTACT INFORMATION (if applicable)

Name:_____

Cell # _____ Email Address _____

PARISH WHERE FAMILY IS REGISTERED:

_____

Circle all PSR grades your child has completed: 1 2 3 4 5 6 7 8 (This is necessary to enable us to assess your child's progress on necessary curriculum and sacramental reception.)

A copy of the Baptismal Certificate is required for all students registering for the PSR program. Please list the dates and churches where the student celebrated the following sacraments:

Baptism

Name of Church _____

Street Address _____

City, State, Zip _____

Date ____/____/____

First Communion:

Name of Church _____

Street Address _____

City, State, Zip Code _____

Date____/____/____

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The following release form will enable my child to participate in all scheduled PSR and Sacramental preparation activities as identified in the PSR Handbook and as amended in the PSR newsletter.

PERMISSION, RELEASE, AND AUTHORIZATION TO SEEK MEDICAL TREATMENT FORM (rev. 7-9-2020)

1. I, the custodial parent/legal guardian of (the "Child"), give permission for my Child to participate in the activity described on the *Activity Information Form* (the "Activity") and release from all liability, indemnify, and hold harmless St. Jude the Apostle School and Parish, the Archdiocese of Cincinnati, the Archbishop of Cincinnati, both individually and as trustee for the Archdiocese, all parishes and schools within the Archdiocese, and all of their agents, representatives, volunteers, and employees from any and all liability, claims, judgments, damages, costs and expenses, including attorneys' fees, arising out of any injury, illness, infectious and/or communicable disease (such as MRSA, influenza, or COVID-19), or death, (including any injury, illness, infectious and/or communicable disease, or death caused by the negligence of Parish and School, the Archbishop, the Archdiocese, any parish or school within the Archdiocese, or any of their agents, representatives, volunteers, or employees) incurred by my Child while participating in the Activity, traveling to or from the Activity, or while using the facilities and equipment of the Parish and School. I further agree not to bring or prosecute or allow to be brought or prosecuted (including, but not limited to, prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits, or actions against Parish and School, the Archbishop, the Archdiocese, all parishes and schools within the Archdiocese, or their agents, representatives, volunteers, and employees.

2. I understand that my Child's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks of injury, illness, infectious and/or communicable disease (such as MRSA, influenza, or COVID-19), and death. I agree that if my Child has underlying health concerns which may place him/her at greater risk of contracting COVID-19 or that would possibly increase the severity of illness if COVID-19 is contracted, then my Child and I will consult with a health care professional before participating in the Activity.

3. I agree to instruct my Child to cooperate with the agents of Parish and School and/or the Archdiocese who oversee the Activity.
4. I authorize the agents of Parish and School and/or the Archdiocese who are acting as leaders of the Activity to seek medical treatment for

my Child in the event of any injury, illness, or medical emergency during the Activity or related travel. I understand that the agents of Parish and School and/or the Archdiocese will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my Child.

5. This Permission, Release, and Authorization is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This Permission, Release, and Authorization shall be construed in accordance with the laws of the State of Ohio, excluding, and irrespective of, any choice of law principles to the contrary.

6. Parish and School, the Archdiocese, the Archbishop and their agents, employees, and volunteers shall have no liability whatsoever in the event the Activity is canceled due, in whole or in part, to any present or future pandemic, epidemic, widespread disease or illness, public health concern, or circumstances arising therefrom, or from actions taken by any governmental or municipal authority to prevent, avoid, or mitigate the impacts thereof.

I have carefully read and understand and accept the terms and conditions stated herein and I acknowledge and agree that this Permission, Release, and Authorization to Seek Medical Treatment shall be effective and binding upon me, my Child, and our personal representatives, estates, assigns, heirs, and next of kin. I have signed below of my own free will.

Signature of Custodial Parent/Legal Guardian Date / /
Print Name: Home Address:_____
Place of Employment &
Address_____

Emergency Contact Phone No. (cell):_____; (other Phone No.): _____

Emergency Medical Preferences (**Required information)
**Doctor's Name: _____ Phone: _____

**Dentist's Name: _____ Phone: _____ **Medical Specialist: _____ Phone: _____ **Local Hospital: _____ Phone: _____

**Facts concerning the child's medical history including chronic conditions, allergies, medications being taken and any physical impairments to which a physician should be alerted:
_____
_____
_____
_____ _____

**Emergency Contact if mother, father, or guardian cannot be reached:
_____

Last Name First Name

_____
_____

Relationship to student Phone number

****All required information must be completed on the Registration Form**

For Office Use Only

Check #_____Amount$_____
Cash Amount$ _____