



# 2017-2018 RELIGIOUS EDUCATION STUDENT REGISTRATION (page 2)

Registered members of Queen of Peace Parish?  Yes  No

Current Parish of Membership: \_\_\_\_\_

**ECE** (Early Childhood Ed) is our faith program for ages 3-Kn

**RE** (Religious Ed) is our faith program for grades 1-6

**YM** (Youth Ministry) is our faith program for grades 7-12

## Family Contact Information

Family Last Name: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Religion: \_\_\_\_\_

Religion: \_\_\_\_\_

## For ALL Parents:

### SPECIAL CONCERNS/NEEDS:

Please let us know of any physical limitations, learning challenges, allergies and/or family circumstances (recent separation, divorce, death or illness). This will be kept confidential.

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

**For ECE Parents:** Will you be at Mass during class?  Yes  No

## For ECE & RE Parents:

### CLASSMATE REQUESTS:

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

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Clinic/Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance Carrier (optional) \_\_\_\_\_

Policy or Group # (optional) \_\_\_\_\_

Medical Liability Release Statement: In the event that neither parent nor emergency contact can be reached, I give permission for an adult member of Our Lady Queen of Peace Catholic Parish Religious Education staff/volunteer corps to administer necessary first aid and/or transport my child(ren) (by ambulance if necessary) to the above mentioned clinic or associated hospital for medical care and treatments as deemed appropriate. I will not hold Our Lady Queen of Peace Catholic Parish, the Diocese of Madison, or any staff/volunteer liable for any injuries my child(ren) may incur while participating in this supervised program.

Parent Signature: \_\_\_\_\_

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

## Additional Contact (other than Parent):

\_\_\_ Mailings should also be sent to this address

Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Cell Phone \_\_\_\_\_

City \_\_\_\_\_

Zip \_\_\_\_\_

## Youth Ministry:

Please indicate student's name and e-mail address:

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