

2018/2019 St. Stanislaus Parish School of Religion (PSR)

HOUR OF POWER

REGISTRATION FORM: GRADES K-5

Contact: LeAnn Korsmeyer, Director of Religious Education ststanleann@socket.net or (573) 690-2882

Student (middle) Name	Birth Date	Grade	Baptism	1 st Reconciliation	1 st Communion
1) _____	_____	_____	Y/N	Y/N	Y/N
Church of Baptism: _____			Member of St. Stanislaus Y/N _____		

Student (middle) Name	Birth Date	Grade	Baptism	1 st Reconciliation	1 st Communion
2) _____	_____	_____	Y/N	Y/N	Y/N
Church of Baptism: _____			Member of St. Stanislaus Y/N _____		

Student (middle) Name	Birth Date	Grade	Baptism	1 st Reconciliation	1 st Communion
3) _____	_____	_____	Y/N	Y/N	Y/N
Church of Baptism: _____			Member of St. Stanislaus Y/N _____		

Mother's (include maiden) Name _____
 Address _____
 Cell # _____ Email _____
 (most communication happens through email)

Catholic ___ Yes ___ No
 Text? ___ Yes ___ No

Father's Name _____
 Address _____
 Cell # _____ Email _____
 (most communication happens through email)

Catholic ___ Yes ___ No
 Text? ___ Yes ___ No

2018/2019 St. Stanislaus Parish School of Religion (PSR)

HOUR OF POWER

REGISTRATION FORM: GRADES K-5

Contact: LeAnn Korsmeyer, Director of Religious Education ststanleann@socket.net or (573) 690-2882

Drop-off and Pick-up Permission Information

I, _____, mother/father of a St. Stanislaus PSR student(s) give my permission to the following individuals to drop-off and pick-up my child(ren) at/from the program when necessary.

Name and relationship:

Phone:

_____	_____
_____	_____
_____	_____

I have read the St. Stanislaus Parish School of Religion **Parent Handbook** Yes ____ No ____

I give permission for my child(ren) photos to be placed on **St. Stanislaus social media pages** if applicable to events relating to the Church. Yes ____ No ____

Mother's Signature _____

Date: _____

Father's Signature _____

Date: _____

2018/2019 St. Stanislaus Parish School of Religion (PSR)**HOUR OF POWER****REGISTRATION FORM: GRADES K-5**

Contact: LeAnn Korsmeyer, Director of Religious Education ststanleann@socket.net or (573) 690-2882

Medical Information

The following information is necessary in case we need to seek emergency treatment for your child. It will be kept confidential to be used only in case of emergency. I understand every attempt will be made to reach me the parent/guardian but if the severity of the injury indicates the necessity, the emergency response system will be called. I authorize emergency treatment to be administered.

Child	List any allergies (food or medical)	Current list of medications	Any other medical concerns
1)			
2)			
3)			

Parent/Guardian Name: _____ Contact: _____

If you cannot be reached in case of an emergency, whom should we call?

Name: _____ Relationship: _____

Phone: _____ Hospital Preference: _____

Physician: _____

Mother's Signature _____

Date: _____

Father's Signature _____

Date: _____