

Blessed Trinity

14040 Puritas Ave.
Cleveland, Ohio 44135
216-671-5890



2011/2012

PSR Registration Student Information

Student's name: _____

Student's address: _____ City _____ ZIP _____

Student's parish: _____ Student's school: _____

Birth Date: _____ Grade Level (in the fall): _____ Student's email: _____

Previous religious Education? Yes No

If yes, Grade levels: _____ Where? _____

Baptism Date: _____ Church: _____ City: _____

Important: If not from Blessed Trinity or previously from Annunciation, Ascension or St. Patrick's, please include a copy of your baptismal certificate.

Confirmation Date: _____ Church: _____ City: _____

First Communion Date: _____ Church _____ City: _____

Parent/Guardian Information

Father's Name: _____ Religion: _____

Address (if different from student): _____

Phone: _____ Email: _____

Mother's Name: _____ Religion: _____

Address (if different from student): _____

Phone: _____ Email: _____

Child lives with: Both parents Mother Father Grandparent/s Legal Guardian
(if applicable)

Phone number for contact (if different from parents' as listed above): _____

Who has permission to pick your child up from PSR? _____

PSR Option you are choosing: (check one)

Sundays, 9:00a -10:45a at Blessed Trinity Parish (Grade 1-Grade 8)

In Home Family Program

PSR begins the week of September 18, 2011.

\$40 tuition due with registration. **\$35 due if returned by June 10, 2011.**

If the tuition creates a hardship, financial assistance in the form of a payment plan is available.

**Blessed Trinity Parish
Parish School of Religion
Emergency Information and Medical Authorization Form**

Emergency Information

Medical: (allergies, conditions, medications, special needs for which we need to be aware):

Emergency Name (if parent cannot be reached): _____

Phone: _____ Relationship to Student: _____

Medical Authorization Form

Purpose:

To enable parents/guardians to authorize emergency treatment for children who become ill or injured while attending P.S.R., when parents/guardians cannot be reached.

Either PART I OR PART II must be completed (Do not complete both parts). PLEASE PRINT

PART I (To Grant Consent)

Children's Names _____

In the event reasonable attempts to contact me at (_____) _____ (phone) or _____ (other parent/guardian) at (_____) _____ (phone) have been unsuccessful, I hereby give my consent for:

(1) the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) or Dr. _____ (preferred dentist) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and

(2) the transfer of the child to _____ (preferred hospital) or any reasonably accessible hospital.

This authorization does not cover any major surgery unless the medical opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

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

Date Parent or Legal Guardian Signature Address

(Do Not Complete Part II If You Completed Part I)

PART II (Refusal to Consent)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take no action or to:

Date Parent or Legal Guardian Signature Address