St. Mary of the Falls PSR

Please check one ☐ New Registration ☐ Re-Registration ☐ Other

Please (X) below the PSR level your child will be entering. Enclose $50.00 class fee. Level 2 has an additional $30 sacramental fee.

PSR for 2024-2025 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Student's Name _____ **Last Name** _____ **Sex** ○ M ○ F

Home Address _____ **City** _____ **Zip** _____

Phone _____ **E-Mail Mom** _____

E-Mail Dad _____

Cell Phone Mom _____ **Cell Phone Dad** _____

City of Birth _____ **Student Date of Birth** _____

Father's Name _____ **Religion Dad** _____

Father's Occupation: _____

Mother's Name _____ **Maiden Name** _____ **Religion Mom** _____

Mother's Occupation: _____

Student Lives With

☐ Both Parents ☐ Guardian
☐ Mother ☐ Father & Stepmother ☐ Other...
☐ Father ☐ Grandparent
☐ Mother & Stepfather ☐ Joint Custody

Registered & Active in Parish? ○ Y ○ N

For NEW students: Please attach a copy of Baptismal Certificate

Baptismal Certificate Attached ○ Y ○ N

Volunteer Help

I am willing to help:

☐ Grades 1-3 Teacher ☐ Substitute Teacher
☐ Grades 1-3 Aide ☐ Traffic Directors at SMOF
☐ Grades 4-5 Teacher ☐ Other...

PLEASE FILL OUT BACK OF THIS FORM----------->

Office Use Only

Fee Paid: Cash____ **Check #** _____ **Amount** _____ **Level 2 Sacramental Fee $30 _____**

Verification of Baptism **Date:** _____ **Church:** _____

Photo/ Video Release: I/we hereby give consent to photograph or videotape aforesaid participant and without limitation to use such photographs or videotapes and or stories about any work of the St. Mary of the Falls PSR without consideration of any kind, and I do hereby release the St. Mary of the Falls PSR Office from any claims whatsoever which may arise in said regard.

Mother/Father or Guardian's SIGNATURE _____ Date:_____

Emergency Form

Purpose: This form enables the parent(s)/guardian(s) to authorize emergency treatment for children who become seriously ill or injured while under the authority of St. Mary of the Falls PSR when parent(s)/guardian(s) cannot be reached.

Student Allergies: _____

Student Medications: _____

Medical Conditions: _____

Emergency Contacts: Please list the names, relationships, and phone numbers of two people to call in case you cannot be reached if your child becomes ill.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

In the event reasonable attempts to contact me at _____ (your phone number) or _____ (other parent's name) at _____ (phone number) have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by Dr. _____ (physician) at _____ (phone number), or Dr. _____ (dentist) at _____ (phone number), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 2) the transfer of my son/daughter to _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Insurance carrier: _____ Policyholder: _____

Parent/Guardian Signature: _____ Date: _____

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Refusal to Consent

I do not give my consent for emergency medical treatment of my son/daughter. In the event of illness or injury requiring emergency treatment, I wish the program director to take no action or to:

_____

Parent/Guardian Signature: _____ Date: _____