



Office of Religious Education – St. Joseph Parish
 373 Winter St. NE
 Salem, OR 97301
 (503) 585-5095

Children's Ministry (1st – 6th grade) Registration Form 2011-2012

**Registration Fee:
 \$30 if received before
 Sept 1, 2011 and \$35
 there after due at time
 to registration**

Child's Information

First Name: _____ Last Name: _____ Home Phone _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Birthday: _____ Grade: _____ School: _____

Parent E-mail: _____

*please note that youth reside with the parents listed.

Parent Name: _____ Day/Cell Phone: _____ Religion: _____

Parent Name: _____ Day/Cell Phone: _____ Religion: _____

Please check (✓) which program your child will be regularly attending:

Wednesday evening first year Sacramental Preparation Program in English 6:45pm – 8:15pm School Classrooms

Wednesday evening second year Sacramental Preparation Program in English 6:45pm – 8:15pm School Classrooms

Last year my child attended (which class) _____

Wednesday evening on-going Faith Formation Classes in English 6:45pm – 8:15pm School Classrooms

Sacramental Formation Information

Sacraments Received: Baptism 1st Holy Communion Reconciliation Confirmation

*Please note that all preparation for sacraments is a two year commitment. If your child is seeking a sacrament, please specify which Sacrament(s) they are seeking _____

Which Mass do you attend: English what time _____ Spanish what time _____ Other _____

Medical Information

Family Physician: _____ Phone: _____ Insurance Company: _____

Policy #: _____ Medical Conditions: _____

Allergies: _____ Medications: _____

Special Needs/Comments: _____

Medical Release

I hereby authorize St. Joseph Catholic Parish, the Archdiocese of Portland in Oregon, its employees, or its representatives to secure the necessary services for my son/daughter in the event of an accident or illness. If necessary, I give permission for him/her to be evaluated, diagnosed, treated, and medicated by licensed medical personnel in accordance with standard medical practice. Further, I, the undersigned, will be solely responsible for the payment of those services.

Parent/Guardian Signature _____ Date _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

For Office Use Only

Date _____ Baptismal Cert. Notes: _____

Amount Paid _____ Cash Check _____

Check # _____ Receipt _____