

Emergency Information

EMERGENCY CONTACT: I authorize the below named contact to authorize medical attention for my child(ren) and/or to pick up my child(ren) if I am not available. Please list someone other than the parents/guardians.

Name: _____ Relationship to Child: _____

Cell Phone :(_____) _____

Emergency

Preferred Hospital, in case of emergency: _____

In the event that I or the family physician indicated above cannot be reached and if, in the judgment of the Parish staff, immediate medical attention is indicated, I authorize the Parish staff to send my child(ren) to an available hospital or physician. I authorize the treatment of my minor child(ren) by qualified emergency medical personnel or licensed medical doctors in the event of an emergency which, in the opinion of the attending emergency medical personnel and/or doctors, may cause physical disability, undue discomfort and/or endangerment of life if delayed. This consent is granted only after a reasonable effort has been made to reach me.

Signature of Parent/Legal Guardian: _____ Date _____

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If there is a step-parent/guardian who you would like to have as a contact, put information below:

Relationship to Child: _____

Name _____

Address _____

City/State/ZIP: _____ Home Phone: (_____) _____

Email: _____

Religion: _____

May this parent/guardian pick up child(ren) from class? _____

Payment Information

Cash or check made out to St. Charles Religious Education.

One Child: **\$70**

Two Children: **\$130**

Three or more Children: **\$190**

Office use only: Date _____ Fee amount paid _____ Check # _____ Cash _____