

# Quick Update Catechesis Registration 2011-2012

St. Joseph Church, Winterset, Iowa

Parent/Guardian Name: \_\_\_\_\_ Date completed \_\_\_\_\_

## Children

Name	Age	Grade	Session Choice
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### Please list any changes of which we should be aware:

*\*If there are significant changes, please complete the full registration form. Thank you!\**

Address: \_\_\_\_\_  
Street City Zip

Mother's Contact Info	Father's Contact Info	Youth Contact Info
Home Phone (____) ____-____	Home Phone (____) ____-____	Cell Phone (____) ____-____
Cell Phone (____) ____-____	Cell Phone (____) ____-____	Email _____
Work Phone (____) ____-____	Work Phone (____) ____-____	
Home Email _____	Home Email _____	
Work Email _____	Work Email _____	

Fees Paid (Date) \_\_\_\_\_ \$25 – 1 Child \_\_\_\_\_ \$45 – 2 Children \_\_\_\_\_ \$60 – 3 or more Children

Please contact the Coordinator for Religious Educations at 515-462-1083 or [hhonkomp@gmail.com](mailto:hhonkomp@gmail.com) if you have any questions or concerns. Thank you.

**Medical/Emergency Information for Children Enrolled in Religious Education**  
*St. Joseph Church, Winterset, Iowa*

Name(s) of Child(ren) \_\_\_\_\_ Medical allergies and/or significant medical history \_\_\_\_\_

Physician: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone

Medical Insurance: \_\_\_\_\_  
Company Name Insurance Number

Emergency contact when parents/guardians cannot be reached:

\_\_\_\_\_  
Name Phone Relationship

**Medical Release:** I hereby authorize the treatment, administration of anesthesia, and surgical treatment(s) for my minor child, in the event of a medical situation occurring in my absence or when the hospital or physicians are *unable to contact me*. This authorization extends to any hospital, physician(s), and nursing personnel within the physician's staff where treatment is rendered by the physicians. I release from medical responsibility and liability the hospital, physicians(s) and nursing personnel for performing medical procedures and acting on the authority of this medical treatment consent form which such medical providers deem necessary for my child. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Dates for which this release is intended: **September 1, 2011 – August 31, 2012**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**If your child has any special learning needs of which we should be aware, or for which he/she is taking medication, please explain and advise of ways we can best help your child:**