

$\frac{\text{ST. LAWRENCE FAITH FORMATION REGISTRATION}}{2017\text{-}2018}$

Office Use Only: Amt Due \$
Amt PD \$
Date PD
CASH or Check #

FAMILY'S LAST NAME		CASH or Check #
FATHER'S NAME		
	CELL PHONE	
E-MAIL		
MOTHER'S NAME	MAIDEN NAME_	
(If different)		
	CELL PHONE	
E-MAIL		
Have you registered at St. Lawrence Parish?	Yes No	

STUDENTS ENROLLING IN RELIGIOUS EDUCATION CLASSES (List Oldest to Youngest)

Child's Name First Last (if different)	Date of Birth	Grade & School	Sacraments			
Last (ii amoront)			Baptism	1 st Communion	Confirmation	
			Yes No	Yes No	Yes No	
			Baptism Yes No	1 st Communion Yes No	Confirmation Yes No	
			Baptism Yes No	1 st Communion Yes No	Confirmation Yes No	
			Baptism Yes No	1 st Communion Yes No	Confirmation Yes No	
			Baptism Yes No	1 st Communion Yes No	Confirmation Yes No	
			Baptism Yes No	1 st Communion Yes No	Confirmation Yes No	

IMPORTANT: Do any of the children named above have any medical needs, allergies, or learning difficulties? If yes, please explain.

I am interested in helpir	ng out with the RE prograr	n as tea	chera	ıide	_ other				
Religious Education office, eve	ES : Parents are required to provien if the child was baptized at St. on, First Communion, or Confirmation	Lawrence. This is							
	first year in our program, please by should already be in our files. If								
REGISTRATION FEES**	(fees are charged to cover	the cost of book	s and mater	ials)					
Make chec	ks payable to St. Lawrenc	e Church.							
\$ 35 (1) chi	ild in Gr. K-8 (<u>**2nd grade s</u>	ee below)							
** \$20 First Rec/Communion extra fee (includes sacramental preparation material)									
\$ 65 (2) children in Gr. K-8									
\$ 90 (3) chi	\$ 90 (3) children in Gr. K-8								
*** If the regis	tration fees are a hardship, please	e contact Donn and	d Michelle.						
	THE COMPLETED FORM AN THE Parish Office or Collection B Parish Office Attn: Religious Ed Registrati St. Lawrence Church 542 Walnut Street Lawrenceburg, IN 47025	Basket in an enve	lope marked '	'Religious I	Education"				
Call Donn and Michelle Paquet	tte at 812-537-0019 (ext. 4) or email	at dpaquette@sls-	apps.org with a	ny questions.	•				
EMERGENCY CONTACT									
PERSON	PHONE	RELA	TIONSHIP						
PHYSICIAN'S NAME	PI	HONE NUMBER_							
treatment and hospital care are co	do hereby consent to whatever x-ray onsidered necessary in the best judgo nember of the medical staff of the hos	ment f the attending	physician, surged	on, or dentist	and performed				
	are to abide by all rules and regu tivities. Any violation of these rules an								
SIGNATURE OF PARENT/GU	JARDIAN	DATE	<u>August 3</u> DATE EF	31, 2018 FECTIVE UNT	ПL				
INSURANCE CARRIER		POLICY	NUMBER						