**For Office Use**

Family Name-
:_____

REGISTRATION 2014 - 2015
Levels PreK thru 6

# St. Gabriel of the Sorrowful Mother PREP

127 E. Howard St.
Stowe, PA 19464
610-327-5376

(Per child fee - $90.)

***Complete Form. PRINT clearly. <u>New registrations</u>: please provide a copy of Baptismal Certificate, if not completed at SGSM.***
***<u>Transfers from another program</u>: please include written proof of participation from program director.***

| Child's Full Name (First, Middle, & Last) | √ if New Reg. | √ if Re-Reg. | Sex M/F | Date of Birth (M-D-Y) | Last PREP Level Completed | Name of Day School & Grade for Current year | Complete if New Reg. Baptism Date & Church (Attach Copy of Certificate) | Complete if New Reg. 1st Penance Date & Church | Complete if New Reg. 1st Communion Date & Church |
|---|---|---|---|---|---|---|---|---|---|
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| | | | | | | | | | |

Family Name: _____ Home Phone #: _____

Address: _____ Email: _____
Street City Zip Code

Father's Name: _____ Work or Cell Phone #: _____ Religion _____

Mother's (Maiden) Name: _____ Work or Cell Phone #: _____ Religion _____

**CUSTODY: Are there any custody/legal issues?** ❑ yes ❑ no (If yes, please provide a complete copy of the latest court order.)

*Name of person responsible for Religious Education if not a Parent/Guardian_____Relationship_____
*Parent/guardian must provide a signed, dated letter of permission to the program director which is to be kept on file and updated annually.

**TURN TO COMPLETE OTHER SIDE -→**

Family Name: (PRINT last name)

# REGISTRATION 2014 - 2015
## Levels PreK thru 6

**EMERGENCY CONTACT INFORMATION:**

If we are unable to reach you, whom should we contact?

Name: _____ Relationship: _____ Phone Number (home) _____

(cell)_____

**CONSENT FOR MEDICAL CARE:**

I give permission that, in my absence, my children whose names appear on page 1 of this registration form, may receive emergency medical care for injuries and all situations that should occur while participating in the Religious Education Program programs and activities at SGSM Parish.

Signed (Parent/Legal Guardian): _____ Date: _____

**MEDICAL/LEARNING DATA**

If any of the following apply to your child, please list his/her name and give details in the appropriate spaces.

| Child's Name | Medical Conditions/Allergies | Prescribed Medications | Disability* / Learning Support Services | Individualized Education Program **IEP** |
|---|---|---|---|---|
| | | | | ❑ YES ❑ NO |
| | | | | ❑ YES ❑ NO |
| | | | | ❑ YES ❑ NO |

If there is other information about your child that should be communicated, please attach to this form.

* As defined by *Individuals with Disabilities Education Act* (IDEA), the term "child with a disability" means a child: "with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and who, by reason thereof, needs special education and related services.

_____ _____ _____

**Signature of Person Completing this Form** **Date** **Relationship to Child(ren)**

Thank you!