

St. Aloysius Gonzaga – Family Registration Form 2009 - 2010

(Registration begins February 2 and ends February 6)

Please identify all children who will attend St. Aloysius Gonzaga School from oldest to youngest:

Last Name	First Name	Grade (09-10)	Date of Birth (mm/dd/yyyy)	Public school child would attend if not at St. Aloysius	Baptized Y - N	Baptized Where? (parish & city)

Children's Address: _____ City: _____ Zip Code: _____ Phone #: _____

Children live with (check one): Both parents Mother Father Guardian Other (explain) _____

FATHER's Name: _____ Religion: _____ Employed by: _____

Father's phone:(home)_____ (work)_____ (cell)_____ Email: _____

MOTHER's Name: _____ Religion: _____ Employed by: _____

Mother's phone:(home)_____ (work)_____ (cell)_____ Email: _____

Custodial Guardian's Name (if applicable): _____ Relationship: _____ Employed by: _____

Guardian's phone:(home)_____ (work)_____ (cell)_____ Email: _____

In case of emergency or illness, please provide additional contacts (*when parents cannot be reached*):

1. Name: _____ (best) Phone #: _____ Relation: _____

2. Name: _____ (best) Phone #: _____ Relation: _____

Please indicate the name and address of the person responsible for tuition payment:

Name: _____

Street Address _____ City _____ ST ____ ZC _____

Signature of person responsible for tuition: _____

(Your signature is permission for St. Aloysius Gonzaga to give only the name and address to FACTS Tuition Management.)

*** Were you referred by a current St. Aloysius School family? If so, who? _____

*** If not referred, how did you hear about us? newspaper ad; cincinnati.com; pre-school flyer; other: _____

Office Use

\$50.00 fee

Date paid: _____

Check #: _____

Reg. with Parish?

Yes No

EMERGENCY TREATMENT AUTHORIZATION

Parents must complete Part I OR Part II

Part I

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or, in event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Physician: _____ Medical Specialist: _____

Dentist: _____ Hospital: _____

Signature of Parent/Guardian: _____ Date: _____

Phone Number: _____

Part II

I don NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian: _____ Date: _____