

# Assumption B.V.M. Faith Formation Family Registration

Office Use Only	
Date Received _____	Medical Info Provided _____
Paid _____	Check # _____

Family Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

In case of emergency call: Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

Child's Name / Email <small>Include last name if different</small>	Date of Birth	Baptism <small>Date/Place</small>	First Eucharist	Confirmation	Completed Reconciliation Workshop	School Attending	Grade	Session/Time <small>MS/HS 6:30, Elem 8:20 or 10:45</small>

Emergency Information - List allergies or other medical information:

  
  
  
  

If your child has a serious medical condition or may need immediate attention, please provide a specific "plan" the catechist or office staff may implement.

  
  
  
  

Parent's Signature \_\_\_\_\_