For Office Use

Family Name:_____

Registered member of St. Michael Parish _____

Fee: _____ Amt. Pd _____ cash _____ck #_____

Parish Religious Education Program Registration Form

St. Michael the Archangel
66 Levittown Parkway
Levittown, PA 19055

Fees
2019 – 2020
$125 one child
$175 two or more
children in one family

Complete Form. Print clearly. For first time registrations, please bring a copy of each child's Baptismal Certificate.

Child's Full Name (First, Middle, & Last)	Sex M/ F	Date of Birth	PREP Level 2019-2020	New to SMA	Name of Day School & Grade	Baptism Date & Parish	1st Penance Year & Parish	1st Communion Year & Parish

Family Name: _____ Home Phone #: _____

Address: _____ **Email**: _____
Street City Zip Code

Are you currently a registered member of St. Michael Parish? (circle one) Yes No If no, where are you registered? _____

Father's Name: _____ Religion _____Cell Phone #_____

Mother's Name: _____ Religion _____ Cell Phone #_____

Mother's Maiden Name: _____

How do you want to be reached by School Messenger? (check all that apply) Cell phone text/call _____ Landline _____ E-mail _____

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 DRE which is to be kept on file and updated annually.

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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 St. Michael the Archangel 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 Please be specific and detailed	Individualized Education Program **IEP or 504 **
				❑ YES ❑ NO
				❑ YES ❑ NO
				❑ YES ❑ NO

**We would like additional information about your child's needs to ensure a pleasant learning experience. Please contact the Religious Education office in person or by phone.

* 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 _____ Date _____ Relationship to Child(ren) _____