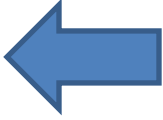


Mary, Undoer of Knots Parish – St. Robert Church

4646 N. Austin Ave. Chicago, IL 60630 - 773-286-0956, faithformationofc@srb-chicago.org

Are you new to the Faith Formation program? (Circle one) **Yes / No** Registration Date: _____

ARE YOU A REGISTERED PARISHIONER? (Circle one) Yes / No PARISH # _____



Family name _____ Home Phone # _____

Address _____ City _____ Zip _____

Father's First & Last Name: _____ Cell # _____

Email Address: _____

Mother's First & Last Name: _____ Cell # _____

Email Address: _____

Emergency Contact Person: _____ Cell # _____
(NAME)

Student Information 2023- 24

Note: A copy of child's Baptism certificate is required when registering, if baptized at a parish other than St. Roberts

| Child's First/Last name | Birth Date (M/D/Y) | Place of Birth | Entering Grade | Baptism Yes / No | First Communion Yes / No |
|-------------------------|--------------------|----------------|----------------|------------------|--------------------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

TUITION – 2023- 24

1 Child - \$230
2 Children - \$300
3+ Children - \$315

+++++For Office use only:+++++

AMOUNT PAID \$ _____ CASH _____ CHECK # _____

Mary, Undoer of Knots Parish – St. Robert Church

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MEDICAL/EMERGENCY INFORMATION & RELEASES

Family Name _____

Student Name _____ Grade _____ Allergies / Special Needs _____

| Student Name | Grade | Allergies / Special Needs |
|--------------|-------|---------------------------|
| | | |
| | | |
| | | |
| | | |

Special circumstances: If your child has any learning challenges, handicaps, illness or other special needs that we should be aware of, please indicate below so we can be attentive to them.

Medical Release

In the event that the undersigned, or my (our) authorized physician cannot be reached and in the judgement of the Director of Faith Formation or other persons responsible for the program or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my child. I (we) hereby authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

⇒ Signature Parents/ Guardian _____ Date: _____

Photo Release

On occasion, St. Robert Bellarmine Faith Formation uses photos and/or academic work of students in school/parish publications to share information about the program. Publications include, but are not limited to: the website, school yearbook, student academic work, advertisements, annual reports, posters, newsletters, parish bulletins and other public relations material.

Check the appropriate box, sign and date your reply

Yes, I grant permission for St. Robert Faith Formation to publish my child's photograph in any format

No, I would prefer that my child's image not be published on any format at this time.

⇒ Signature of Parent/Guardian _____ Date: _____

*******For Office use only:*******

Date Information Entered Into Student File: _____ Entered by: _____