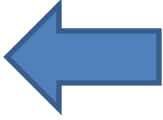


# Mary, Undoer of Knots Parish – St. Robert Church

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 2026 - 27

*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.					

<p><b>TUITION</b>                  Book \$20                  1 Child - \$230                  2 Children - \$300                  3+ Children - \$315</p>
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+++++For Office use only:+++++

AMOUNT PAID \$ \_\_\_\_\_ CASH \_\_\_\_\_ CHECK # \_\_\_\_\_

AMOUNT PAID \$ \_\_\_\_\_ CASH \_\_\_\_\_ CHECK # \_\_\_\_\_

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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: \_\_\_\_\_