2020-2021
Our Lady of Guadalupe Parish Religious Education Program
5194 Cold Spring Creamery Road
Tel: 267-247-5374 Fax: 267-247-5402

PREP Registration Form

For Office Use Only:

Class Name:________________

Class Day:_________________

Room #: ___________________

Family Information

Family Last Name: _________________________________ E-mail (required):____ Preferred Phone #:__________________

Father's Name: ____________________________________ Mother's Name:______________________________________ Parental Marital Status:_________________

Address:____

Number & Street City State Zip

Father Cell Phone #:___________________________________ Mother Cell Phone #: ________________________________

Student Information

Child's Full Name	Gender	DOB	Grade Level	Name of School	Baptism Date & Parish Name**	Date of 1st Reconciliation	Date of 1st Communion	Sacrament Year – Y/N

****For new students and students entering 2nd grade, please attach or send in a copy of each child's baptismal certificate**

Program of Choice: Weekly (Online for FA20) _______ Family Catechesis (Homeschool) ______

______ I give permission for my child's Catechist and OLG PREP staff and volunteers to contact my child as necessary for educational purposes through the established electronic means as outlined in the PREP 2020-21 Handbook, including but not limited to video chat services such as Zoom and Facetime.

______ I give permission for my child's picture to appear on the Our Lady of Guadalupe parish website, bulletin, and/or social network page (initial) associated with the work of the PREP program.

Parent/Guardian Signature ____________________________________Date__________Relationship to Child(ren)_____________________________

Emergency Contact/Consent

Emergency Contact: Name____ Relationship to Child(ren)__________________________________

Phone(s): ____

Parental Consent for Medical Care: In case of an emergency, **I give permission for my child to receive emergency medical treatment and, if necessary, be transported to the nearest medical facility.**

Signed (Parent/Legal Guardian): ____ Date: _______________________

Medical/Learning Data

If any of the following apply to your child(ren), please list his/her name and give details in the appropriate places

Child's Name	Medical Conditions/Allergies	Prescribed medications	Disability* / Learning Support Services	**IEP** (Individualized Education Plan)
				Yes____ No____
				Yes____ No____
				Yes____ No____

Is there any information you would like to communicate about your child(ren)?

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*As defined by *Individuals with Disabilities Education Act (IDEA)*, the term "child with a disability" means a child: "with intellectual disability, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), 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.

For Office Use Only – Payment Information:
Date: __________ Amount: ___________ Cash/Check: __________ Date: ___________ Amount: ____________ Cash/Check: __________