**HOLY CROSS FAITH FORMATION REGISTRATION FORM**

**(Each child must have an updated Health History Form on file)**

Family Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mom’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mom’s Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dad’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dad’s Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

Marital Status: Married\_\_\_\_\_\_ Divorced \_\_\_\_\_\_ Single \_\_\_\_\_\_ Widow/Widower\_\_\_\_\_\_

Names of Children to be enrolled:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First and Middle Name**  and Last Name *(if*  *different from family*  *name)* | **M**  **or**  **F** | **Birth**  **Date** | **School Attending** | **Grade** | **Sacraments**  **Received** |
|  |  |  |  |  | *Baptism* Y or N  *Communion* Y or N  *Confirmation* Y or N |
|  |  |  |  |  | *Baptism* Y or N  *Communion* Y or N  *Confirmation* Y or N |
|  |  |  |  |  | *Baptism* Y or N  *Communion* Y or N  *Confirmation* Y or N |
|  |  |  |  |  | *Baptism* Y or N  *Communion* Y or N  *Confirmation* Y or N |
|  |  |  |  |  | *Baptism* Y or N  *Communion* Y or N  *Confirmation* Y or N |

**Registration Fee K-7th Grade $50 per child $\_\_\_\_\_\_\_\_\_**

**($5 late fee per child for late registration after August 31, 2019)**

**Sacramental Fee for First Communion Candidates $50 per child $\_\_\_\_\_\_\_\_\_**

**Total Family Registration Fee ($200 per family--Including Confirmation fees) $\_\_\_\_\_\_\_\_\_**

***For the sacrament of Confirmation and Youth Ministry for High School Teens,***

***please contact Denys Davis at: holycrossyouthministry@yahoo.com or 336-497-1408***

FOR OFFICE USE ONLY:

Amount Paid\_\_\_\_\_\_\_\_\_ Check #\_\_\_\_\_\_\_\_\_\_\_Unable to pay\_\_\_\_\_\_\_\_\_ Catechist\_\_\_\_\_\_\_\_\_\_\_

HEALTH HISTORY FORM

If you have an updated health form on file, you do not need to complete this side of the form

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET, CITY & ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_\_\_\_\_

MOTHER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL NO (\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL NO (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE

PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE

MEDICAL INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPANY NAME POLICY #

**A. ILLNESSES AND INJURIES (CHECK THOSE THAT APPLY)**

\_\_\_\_\_ASTHMA \_\_\_\_\_DIABETES \_\_\_\_\_EPILEPSY \_\_\_\_\_KIDNEY DISEASE

\_\_\_\_\_CONVULSIONS/SEIZURES \_\_\_\_\_EAR INFECTION \_\_\_\_\_HEART DISEASE

DATE OF LAST HEALTH EXAM\_\_\_\_\_\_\_\_\_\_\_\_\_ ANY MEDICAL PROBLEMS NOTED?\_\_\_\_\_

IF YES, PLEASE EXPLAIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SINCE CHILD’S LAST EXAM HAS HE/SHE HAD:

A SERIOUS ILLNESS\_\_\_\_\_\_ WHAT?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AN ILLNESS LASTING LONGER THAN A WEEK? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AN OPERATION OR FRACTURE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TREATMENT IN A HOSPITAL OR EMERGENGY ROOM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESTRICTIONS FROM PHYSICAL ACTIVITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATION TO BE TAKEN ON A REGULAR BASIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. ALLERGIES (CHECK THOSE THAT APPLY)**

\_\_\_\_\_\_ANIMALS \_\_\_\_\_\_MEDICINES \_\_\_\_\_\_INSECT STINGS \_\_\_\_\_FOOD

\_\_\_\_\_\_PLANTS \_\_\_\_\_\_HAYFEVER \_\_\_\_\_\_POLLEN \_\_\_\_\_OTHER

PLEASE SPECIFY IF ANY ARE CHECKED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# C. IMMUNIZATIONS

IMMUNIZATION YEAR PRIMARY SERIES COMPLETED YEAR OF LAST BOOSTER

DPT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEASLES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MUMPS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORAL POLIO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RUBELLA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TB TINE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHICKEN POX \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIB HEPATITIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. OTHER HEALTH CONDITIONS—Medical and/or Learning Disabilities:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E. PERMISSION TO SEEK MEDICAL HELP**

IF I CANNOT BE REACHED IN CASE OF EMERGENCY, THE BEARER OF THIS FORM IS AUTHORIZED TO ACT ON MY BEHALF TO SEEK MEDICAL TREATMENT AS THEY DEEM NECESSARY FOR MY CHILD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN DATE