

## 2008-2009 Pax Christi Catholic Church Preschool-12<sup>th</sup> Grade Registration

Choose the activities from the Pax Christi Growing in Faith Opportunities for All Ages Handbook, then fill in the chart below. Please use one line for each different program.

Name	Grade	M/F	activity code	fee
<b>Total (maximum of \$120/family)</b>	-----	-----	-----	
<b>Discount for catechists</b> receive a \$20 discount every time you are a catechist! (1 program - \$20, 2 programs - \$40, etc.) please see other yellow form for all catechist ministry options	-----	-----	-----	-
<b>Total after discounts - check enclosed</b>	-----	-----	-----	

Scholarships are available.

Mother/Guardian name: _____	Father/Guardian name _____
Address _____	Address _____
Home phone # _____	Home phone # _____
Cell phone # _____	Cell phone # _____
Email address: _____	Email address: _____

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

Please return by September 1, 2008 make checks payable to:

Pax Christi Catholic Church     4135 18 AVE NW Rochester, MN 55901  
paxchristchurch.org                     (507) 282-8542

Photos/videos may be taken for publicity purposes.

If you would **not** like photos to be taken, please contact the church office.

office use:

date received \_\_\_\_\_ \$ \_\_\_\_\_ check # \_\_\_\_\_

# Pax Christi Catholic Church preschool-12<sup>th</sup> Grade Medical Information

(please use one section for each child - please make additional copies if needed or access form at [www.paxchristiyouth.org](http://www.paxchristiyouth.org))

## **GENERAL MEDICAL INFORMATION:**

\* information will be kept in a confidential file and shared only with catechists and coordinator.\*

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Parent name(s): \_\_\_\_\_

Allergic Reactions (medications, foods, plants, insects, etc...): \_\_\_\_\_

Any special medical conditions we should be aware of (chronic illnesses, physical limitations, medically prescribed diet, recently exposed to contagious diseases such as mumps, measles, chicken pox, etc.): \_\_\_\_\_

Medications: \_\_\_\_\_

Please sign below IF you grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup, Tylenol, etc.) to be given to your child, if deemed appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Please enclose a copy of insurance card both back and front. \*\***

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