St. Helen CATHOLIC CHURCH

ST. HELEN RELIGIOUS EDUCATION
CCD REGISTRATION

Student Name: ____ DOB___/___/___

Student's School: ____

Address:____

____

Mother's Name: ____ Maiden: ______________________

Religion: ___________________________________ Marital Status: _____________________________

Home Phone: _________________ Cell Phone: ________________ Work Phone: _______________

Email Address: ____

Place of Employment: ____

Father's Name: ____

Religion: ___________________________________ Marital Status: _____________________________

Home Phone: _________________ Cell Phone: ________________ Work Phone: _______________

Email Address: ____

Place of Employment: ____

Registered Parishioner of St. Helen? YES NO If YES, Parish ID number: ______________________

If you do not know your parish ID, call 772-567-5129

SACRAMENTS

BAPTISM
Date:____________ Church:______________________ Address: _____________________________

HOLY EUCHARIST:
Date:____________ Church:______________________ Address: _____________________________

CONFIRMATION:
Date:____________ Church:______________________ Address: _____________________________

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Person(s) Authorized to Pick Up My Child

This information MUST be filled out by a parent or guardian

The following person(s) have my permission to drop off and / or pick up my child while attending St. Helen CCD program:

1. ____ Phone: ___________________

2. ____ Phone: ___________________

While your child is under our care it is important to have the following information.
Who should we contact in case of emergency:

1. ____ Phone: ___________________

2. ____ Phone: ___________________

Medical Information
Are there any allergies, medications, conditions or special needs your child requires that you would like us to be aware of? YES NO

If yes, please explain:
____
____
____
____

If we are unable to contact you or the person(s) you designated as emergency contacts, do you give us permission to provide appropriate medical action should your child require it while attending CCD classes?

YES NO

If YES, which hospital would you prefer your child to be taken to?

_____ Cleveland Clinic (Indian River)

_____ Sebastian Medical Center

Please note that the parents will be called FIRST in the event of an emergency.

Name of Doctor: ______________________________________ Phone: ___________________

Parent / Guardian Signature: ____
Date

St. Helen Catholic Church / Religious Education Office
2005 Tallahassee Ave. Vero Beach, Fl. 32960
P: (772) 562-5954 / E: pfies@sthelenvero.org

St. Helen CATHOLIC CHURCH

CCD GRADE LEVEL

GRADE	YEAR	PAID
CIC		
K		
1ST		
2ND		
3RD		
4TH		
5TH		
6TH		
7TH		

REMARKS:

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____
____

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