

PSR Gr 1-8 RETURNING STUDENTS
Registration Form

Please write family name here: _____

Please write email address here: _____

Returning Students (Please note New Sibling with * and fill out New Student Forms for new students)

Student Name _____ Grade entering _____ (Continue on back if needed)

To save you precious time, complete the following sections only with any changes in the past year, i.e. new address, different phones, doctors, etc. Previous data is already in our computer records. For questions, email Becky at bready@sttm.org or Kate Roelker at kroelker@sttm.org.

Registration Form Please check one: ___ Changes ___ No Changes

Family name/address/phones/marital status/email changes

Medical Authorization Please check one: ___ Changes ___ No Changes

Business Name/Phone: _____

Emergency Name/Phone: _____

Physicians/Phone/Hospital: _____

Photo Release Form (Please sign and date one of the following approval or Not)

Approval: Signature/Date _____

NOT Approved: Signature/Date _____

TUITION FEE: ___ \$85 one child ___ \$145 two children ___ \$190 three or more

Check #: _____ Payable to St. Thomas More Parish

For Visa/MC please complete attached form. (3%fee included)

Enclose registration form and payment in envelope and return to St. Thomas More Faith Formation Office, 800 Ohio Pike, Cincinnati, OH 45245

PLEASE SUBMIT PSR FORM AS SOON AS POSSIBLE!!!

EMERGENCY MEDICAL AUTHORIZATION FORM

Child's Name: _____

Father's Name: _____

Mother's Name: _____

Address: _____ City/St/Zip: _____

Home Phone: _____ Cell/Other: _____

Consent: Please complete Part 1 or 2: This is to enable parents'/guardians to authorize the provision of emergency treatment to children who become ill or injured under Nursery authority, when parents or guardians cannot be reached.

Part 1: To Grant Consent

In the event reasonable attempts to contact me at (phone) _____ or _____ (other parent/guardian phone) _____ have been unsuccessful, I hereby give my consent for: The administration of any treatment deemed necessary by Dr. (preferred physician) _____ at (phone) _____ or Dr. (dentist) _____ (phone) _____ or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and the transfer of the child to (preferred hospital) _____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before surgery is performed.

Parent / Guardian Signature: _____ Date: _____

Part 2: Refusal to Consent (do not sign if completed Part 1)

I **do not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Nursery authorities to take no action:

Parent /Guardian Signature: _____ Date: _____

MANDATORY CHILD PROTECTION CERTIFICATION

In order to maintain safety guidelines, the Archdiocese of Cincinnati mandates that all Volunteers, who work with children, must have completed the Virtus Protecting God's Children Class, must have completed a Background Check and been Approved through Selection.com, and must be up to date on their Virtus Training Bulletins. Virtus classes may be taken anywhere in the Archdiocese by registering at <https://www.virtusonline.org/>

_____ **Yes, I have been certified** _____ **No, I have not been certified**