PSR PRESCHOOL RETURNING STUDENTS
Registration Form

Please write family name here:_____
Please write email address here:_____

Returning Students (Please note New Sibling with *)
Student Name Age (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: ____$10 one child ____$20 two children ____$30 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 Attn: Kate Roelker

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**