



**Saint Matthew**  
CATHOLIC CHURCH

1303 Lincolnshire Drive, Champaign, IL 61822 — (217) 359-4224

# CCD RELIGIOUS EDUCATION 2018–2019 REGISTRATION FORM

PRESCHOOL—8<sup>TH</sup> GRADE

**CLASSES BEGIN SEPTEMBER 9, 2018**

Sundays at St. Matthew School

9:30am–10:30am — Preschool (3 yr. old & 4 yr. old)

10:45am–12:00pm — Grades K–8

**PLEASE PRINT ALL INFORMATION CLEARLY. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY. ONE FORM PER FAMILY.**

## GENERAL FAMILY INFORMATION:

Family/Last Name \_\_\_\_\_ Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Name (First/Last) \_\_\_\_\_ Religion \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Father's Mailing Address, if different from above (Street Address/City/State/Zip) \_\_\_\_\_

Mother's Name (First/Maiden/Last) \_\_\_\_\_ Religion \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Mother's Mailing Address, if different from above (Street Address/City/State/Zip) \_\_\_\_\_

Are you registered members of St. Matthew Parish? (Yes/No) Father \_\_\_\_\_ Mother \_\_\_\_\_ Child(ren) \_\_\_\_\_

## STUDENT INFORMATION:

***\*If this is your child's first year of CCD at St. Matthew, you must submit a copy of their Baptismal Certificate to the Religious Education Office before Fall 2018 classes begin, unless they were baptized at St. Matthew.***

Child's Name	Date of Birth	Grade in Fall 2018	Known Allergies & Medical Info (including medications and/or cognitive/learning disabilities)	Sacraments Received (Please indicate date and location if not received at St. Matthew)			
				Baptism	First Reconciliation	First Communion	Confirmation
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please also complete and sign the reverse side. →**

**General Permission**

I request that my child(ren), \_\_\_\_\_, be allowed to attend the CCD Program located at/in **St. Matthew Parish/School** which takes place: **September 2018—May 2019**. I hereby release and agree to indemnify and hold harmless the parish, its staff and their employees and agents, volunteers, and the Catholic Diocese of Peoria from any and all liability, for injuries, damages, medical expenses or any other loss to my child(ren) or family, including attorney fees, arising from claims of any kind or nature whatsoever from my child’s participation in this event.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Permission Form**

I grant permission for the administration of First Aid to my child(ren), \_\_\_\_\_, by the people in charge of the CCD Program, to sign the necessary releases as may be required, and to make the necessary referrals to qualified physicians for the treatment of illness or accidents of a more serious nature. I understand I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In the case of a medical emergency, I understand that every effort will be made to contact the parent/guardian of the participant. In the event that I cannot be reached, I hereby give permission to the physicians selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery if deemed necessary for my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Information:**

Policy Holder (in the name of): \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Identification #: \_\_\_\_\_

Authorized Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Authorized Hospital: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Emergency Contact:**

In case of emergency, when parent(s)/guardian(s) can’t be reached, please contact: \_\_\_\_\_

Relationship to child(ren): \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Videotaping and Still Photographs:**

Video, still photographs, and audio recordings may be taken during the CCD Program. This authorization form constitutes permission for my child’s participation in videotaping, still photographs, and/or audio recordings, which may be used for future promotional efforts, including St. Matthew Parish and the Catholic Diocese of Peoria publications and websites.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YOUR HELP IS NEEDED!**

I am interested in learning more about becoming a:

*Catechist* \_\_\_\_\_ *Co-Catechist (Team Teaching)* \_\_\_\_\_ *Substitute Catechist* \_\_\_\_\_ *Classroom Aide* \_\_\_\_\_

All training and materials are provided. No previous experience required. Volunteers must be 13 years of age or older. Youth and adult volunteers are needed.

**Please mark # of children on appropriate line(s) below:**

\_\_\_\_\_ \$60 for one child

\_\_\_\_\_ \$50 for each additional child

*If you require financial assistance, please complete a Scholarship form*

**Return One Form**

**Per Family To:**

St. Matthew Parish  
Religious Education Office  
1303 Lincolnshire Dr.  
Champaign, IL 61821

**Make Checks Payable To:**

St. Matthew Parish

**Office Use Only:**

Total Due: \_\_\_\_\_

Total Paid: \_\_\_\_\_

Date Paid: \_\_\_\_\_

Check #/Cash: \_\_\_\_\_

Notes: \_\_\_\_\_