



**ST. ELIZABETH OF HUNGARY CATHOLIC CHURCH  
2010-2011 RELIGIOUS EDUCATION PROGRAM**

*Registration Form (High School Only)*

**Registration Fee: \$125**

**\$35 registration fee due at time of registration & \$90 Retreat Fee (confirmation class only) due by January 1**

**Classes are held on Wednesday from 7 to 8:30 p.m.**

**Have you completed Religious Education in grades 7<sup>th</sup> & 8<sup>th</sup> or are currently enrolled in a Catholic school or have completed the Introduction to Confirmation Class?  Yes  No**

If **NO**, you must complete Introduction to Confirmation before you can take the Confirmation Class. {Fee \$35}

Last Name		First & Middle Name		Date of Birth	M/F	Grade
Mailing Address		City / Zip				
Mother's Cell Phone	Mother's Name (including maiden)					
Father's Cell Phone	Father's Name		Email Address			
Student's Personal Email Address				Student's Cell Phone		

Mailing address above is for:  Both Parents  Mother  Father  Other Guardian \_\_\_\_\_  
Alternate Mailing Address (if needed): \_\_\_\_\_

Is your family a registered member of St. Elizabeth?  Yes  No

**HAS STUDENT RECEIVED THE SACRAMENTS OF BAPTISM & FIRST COMMUNION?  Yes  No**

Church of Baptism \_\_\_\_\_ City/State of Baptism \_\_\_\_\_  
(A COPY OF PROOF OF BAPTISM REQUIRE BY NOVEMBER 1)  Copy of Baptism Certificate Attached

*IF NO, PLEASE COMPLETE PAPERWORK FOR RCIA CLASS. RCIA Adapted for Children is held on Tuesday @ 6:30 pm*

**CLASS REQUEST:**

- INTRO TO CONFIRMATION** (high school students who have not attended Catechism in the last 3 years)
- CONFIRMATION:**  Session 1 / September- November     Session 2 / January -March

**Scholarships available / See Drige or Tressi for more information**

**MEDICAL RELEASE**

*I authorize a representative of St. Elizabeth Religious Education Program to consent medical treatment of the above named student in the event of an emergency. I, the undersigned, have read this Release and Consent of Medical Treatment and understand all of its terms and conditions.*

Insurance Carrier & Name of Insured	Cardholder's Date of Birth	Policy/Group #	ID #
Does your child have any Special Learning Needs, Dietary Needs or Allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, please explain:	
Emergency Contact & Cell Number(other than parents listed above):			
Parent/Guardian Signature		Date	

**FOR OFFICE USE:** Amount Due \$ \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_ Cash / Check # \_\_\_\_\_ Balance Due\$ \_\_\_\_\_  
 Parent is Catechist or Weekly Volunteer    *Registration Completed by (Initials)* \_\_\_\_\_ / *Date* \_\_\_\_\_