The Basilica of St. John the Baptist
627 McKinley Avenue NW
Canton, Ohio 44703

330-454-8044

St. Peter Roman Catholic Church
726 Cleveland Ave NW
Canton, Ohio 44702

330-453-8493

CCD Registration
2018-2019

Student Information

Student Name: Last: ____________________ **First:** ____________________ **Middle:** __________________

Date of Birth: ___________________ **Address:** ____

(Street Address) *(City/Zip Code)*

Parish: _______________________________________

School: _______________________________________ **City:** ____________________ **Grade:** ____

Sacramental Information	Month	Day	Year	Church	City	State
Baptism						
First Reconciliation						
First Holy Communion						
Confirmation						

Parent/Guardian Information

Father's Name: Last: ________________________ **First:** _____________________ **Religion:** _____________

Mother's Name: Last: ________________________ **First:** ____________________ **Religion:** ______________

Mother's Maiden Name: ______________________

(or)

Legal Guardian's Name: Last: ____________________ **First:** ___________________ **Religion:** _____________

Legal Guardian's Name: Last: ____________________ **First:** ___________________ **Religion:** ______________

Primary Phone: ___________________ **Address:** ____

(Street Address) *(City/Zip Code)*

Primary Contact for Standard and Emergency Communications

(In the event that CCD is cancelled this person will be contacted.)

Name: Last: ______________________ First: ______________________ Middle: ______________________

Relation to Student: ______________________________ Email Address: ____________________________

Phone: Home: _______________________ Cell: ______________________ Work: _____________________

Additional Emergency Contacts

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Permission to Pick-Up and Drop-Off

(The following persons have permission to pick-up and drop-off your child.)

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Name: ________________________ Phone: _____________________ Relation: _________________________

Religious Education Fee

One Student: $25.00

Family Rate (two or more students): $40.00

I will pay via mail:

I will pay via e-giving:

Parent/Guardian Signature: ____ Date:________________

The Basilica of St. John the Baptist & St. Peter Roman Catholic Church
Religious Education Program Emergency Medical Authorization 2018-2019

Student Name: Last: ____________________ **First:** ____________________ **Middle:** ________________

Address: ____
(Street Address) *(City/Zip Code)*

Complete Either Part I or Part II Below

Part I: To Grant Consent
In the event reasonable attempts to contact a parent/guardian have been unsuccessful, *I hereby give my consent* for the administration of any treatment deemed necessary by the designated preferred physician or dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to the preferred hospital or any hospital reasonably accessible.

Mother/Guardian: ____ **Phone:** ________________________

Father/Guardian: ____ **Phone:** ________________________

Other person to contact if parent cannot be reached: ____

Relationship: ___________________ **Home Phone:** __________________ **Cell Phone:** _______________

Preferred Physician: ___________________________________ **Phone:** ____________________________

Preferred Dentist: ___________________________________ **Phone:** ____________________________

Medical Specialist: ___________________________________ **Phone:** ____________________________

Preferred Hospital: ___________________________________ **Phone:** ____________________________

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which we or a physician should be alerted:
____
____
____
____

Parent/Guardian Signature: ____ **Date:** _____________

Part II: Refusal to Grant Consent *(do not complete if you have signed part I)*
I do not give my consent to emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish the school authorities to take the following action:
____
____
____

Parent/Guardian Signature: ____ **Date:** _____________