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
2019-2020

Student Information

Student Name: Last: _____ **First:** _____ **Middle:** _____

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

Date of Birth: _____ **Place of Birth:** _____ **Current Age:** ____

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 Contact for Standard and Emergency Communications

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

Name: Last: _____ First: _____

Relation to Student: _____ Email Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Additional Emergency Contacts

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: _____

Photo/Visual Consent

- ☐ I give permission for my child to be photographed or videotaped at the Basilica of St. John the Baptist and St. Peter Catholic Church. I realize that the photo or video may be published in the parish bulletin, on the parish website, or in another publication deemed appropriate by the parish for informational or educational purposes regarding the parish's programs or curriculum.

(or)

- ☐ I have read the photo/visual consent and do NOT give permission for my child to the above request.

Permission to Publish on the Internet

- ☐ I give the Basilica of St. John the Baptist and St. Peter Catholic Church the right to use the following student material from my child for inclusion on the internet on the parish website and parish social media accounts, including Facebook, Instagram, and Twitter. I affirm that I have the legal right to issue such consent.

Check ALL that apply. (A blank space indicates the intent of the parent or guardian to NOT allow that information on the parish Website and social media accounts.

- ☐ First name only
- ☐ Group photograph
- ☐ Individual student photograph
- ☐ Photo of Student work

Parent/Guardian Signature: _____ Date_____

(Signature affirms your answers to the above questions and confirms that all of the information above is correct.)

Emergency Medical Authorization

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:** _____