



Most Blessed
Sacrament
Parish School
4255 Bellevue Road
Toledo, Ohio 43613

REGISTRATION FORM 2023/2024

(To be completed by Responsible Party)

419-472-1121

PARISHIONER? Yes No If yes, what Parish? _____

Family Last Name

Primary Phone

Primary Guardian: Last/First

Address	City	State	Zip	STUDENT NAME (INCLUDE M.I.)		ETR / IEP?	GRADE ENTERING	BIRTH DATE	SEX	RACE	CATHOLIC	BAPTIZED Where?
Please list oldest to youngest.				<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PARENT INFORMATION

<u>Father's Name</u>	<u>Mother's Name</u>	<u>Step Father's Name (if applicable)</u>
Address	Address	Home Phone
Employer	Employer	Cell Phone
Home Phone	Home Phone	Work Phone
Cell Phone	Cell Phone	Email
Work Phone	Work Phone	<u>Step Mother's Name (if applicable)</u>
Email *(Required)*	Email *(Required)*	Home Phone
Parent's Marital Status: <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widowed <input type="radio"/> Divorced		Cell Phone
A copy of custody determination must be on file in the school office. If parents have joint Custody and want the school information sent to both, please submit both email addresses.		Work Phone
Student Lives with: _____ Email correspondence regarding school information should be sent to:		Email
		Failure to reveal an IEP/ETR could result in the loss of acceptance into the school.

PRIMARY GUARDIAN _____

PRIMARY PHONE _____

FAMILY EMERGENCY PROCEDURE/AUTHORIZATION FORM & MEDICAL INFORMATION

1 Please list serious illnesses, injuries or health conditions that may affect learning i.e. vision.

2 List all allergies (food, insects, etc).

3 List all medications your child takes on a regular basis or seasonally.

STUDENT NAME	ILLNESSES	ALLERGIES	MEDICATIONS <i>Include dosage & times taken</i>	PARTICIPATION
				Is there any reason this child cannot fully participate in all school activities __Yes __No Explain:
				Is there any reason this child cannot fully participate in all school activities __Yes __No Explain:
				Is there any reason this child cannot fully participate in all school activities __Yes __No Explain:
				Is there any reason this child cannot fully participate in all school activities __Yes __No Explain:

PRIMARY GUARDIAN: _____

PRIMARY PHONE: _____

EMERGENCY CONTACT INFORMATION: In case of illness or accident, if I/We (the parents or guardians) cannot be reached at the numbers listed on this form, you have my permission to contact/and if necessary, release student to the following:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Family Doctor: _____ Phone: _____ Dentist: _____ Phone: _____

Emergency Hospital: _____ or any hospital reasonably accessible.

CHECK ONE: In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by above names doctors or (2) the transfer of the child to the above designated hospital or any hospital reasonably accessible.

I do not give my consent for 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.

TRANSPORTATION INFORMATION

Please indicate the main means of transportation that will be utilized by this/these student(s) upon daily dismissal from school.

NOTE: Changes to dismissal transportation can only be made by the legal guardian(s).

If a problem arises, please supply a phone number where a parent or caregiver can be reached at dismissal. Phone #: _____

Please indicate the main means of transportation that will be utilized by this/these student(s) upon daily school dismissal. Please circle the days that are applicable:

Other If your child(ren) has/have some combination of the adjacent options, please indicate that below so that staff members are fully aware.

Walker M T W T F _____

Car Rider M T W T F _____

Washington Local Bus Rider M T W T F _____

After School Care M T W T F _____

FURTHER TRANSPORTATION INFORMATION: List adults authorized to pick up your student(s).

NAME	PHONE	RELATIONSHIP

Signature of Parent/ Guardian: _____ Date: _____