

St. Olaf Catholic Church  
 18943 Caldart Avenue NE  
 Poulsbo, WA 98370  
 (360) 779-4291

# RETURNING STUDENT REGISTRATION

FOR OFFICE USE  
 ONLY:  
 Date Received

**Faith Formation**  
 Religious Education Program  
 2016-17

(Please Print)

Please fill out **ONE FORM FOR EACH CHILD.**

Have there been any **CHANGES SINCE LAST YEAR?**

Please **CHECK YES/NO BOXES** below and enter new information as needed.

### STUDENT INFORMATION

<b>Last Name</b> (Last name used at school)		<b>First Name</b>		<b>Middle Initial</b>
<b>Nickname</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Date of Birth</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Name of School</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Grade</b> (2016-17 School Year)	

### SACRAMENTS OF INITIATION

Please check below if your child will be taking Sacramental Initiation classes **THIS YEAR** in:

<b>Reconciliation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Confession: Usually Grade 2)</small>	<b>Eucharist</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Communion: Usually Grade 2)</small>	<input type="checkbox"/> <b>Confirmation</b> <small>(Age 16 by Easter 2017)</small>
<b>At least ONE PARENT is required to attend above classes with child.</b>		
<b>Was your child baptized at St. Olaf?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, a copy of their Baptism Certificate IS <b><u>NOT REQUIRED</u></b> for Sacramental Initiation Classes.)</small>		
<small>(If no, A COPY OF BAPTISM CERTIFICATE IS <b><u>REQUIRED</u></b> for Sacramental Initiation classes.)</small>		
If <b>NOT</b> baptized at St. Olaf, WHERE was your child baptized?		
<b>Name of Church where Baptized</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Date Baptized</b>	<b>City, State, Zip, Country</b>
<b>Did your child receive First Communion at St Olaf?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, no copy of certificate needed.) (If no, no action required.)</small>		

### STUDENT MEDICAL HISTORY

<b>Please explain any medical conditions we should be aware of.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Allergies</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, please explain allergies.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

### LOCAL EMERGENCY CONTACT

<b>Name</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Relationship to Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Phone Number</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IN CASE OF EMERGENCY, if parent/guardian or local contact cannot be reached,</b> the bearer of this form is authorized to act on your behalf to seek medical treatment, as deemed necessary, for the child registered on this form.		
<b>Parent/Guardian Signature</b>		<b>Date</b>

Please submit completed registration forms to Kim Baumann at the Parish Office or R.E. Building

**QUESTIONS?** Call Kim at 360-779-4291, Ext. 105, or email at stolaafformation@embarqmail.com