

2009-10

**Catholic Education Program  
(CEP)  
Registration Form  
Prek—5th grade**

**Please fill out both sides and return to:**

St. Thomas More Newman Center  
701 Maryland Ave.  
Columbia, MO 65201

Received \_\_\_\_\_

Amount \_\_\_\_\_

Check # \_\_\_\_\_

Cash \_\_\_\_\_



Family Name: \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone(h) \_\_\_\_\_ Phone(cell) \_\_\_\_\_

Father's Religion \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone(h) \_\_\_\_\_ Phone(cell) \_\_\_\_\_

Mother's Religion \_\_\_\_\_

Child's Primary address: \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_

Email (if regularly used) Father's \_\_\_\_\_ Mother's \_\_\_\_\_  
(CEP correspondence is often sent by email)

**CEP Information**

**Elementary sessions** (Prek-5th grade) are held: Sun. Mornings *10:00-10:55 am* and  
Wed. evenings 6:45-7:45 pm

**Cost: \$45 per child**

Registration begins in April for the following fall. Placement in Elementary sessions is  
based upon when the registration forms are returned to Newman Center.

**I prefer my Elementary age child/ren to attend (circle one):**

**Sunday Wednesday No preference**

Child's Name	Birth date	Grade 2009-10	Baptized?	1st Reconcilia- tion?	1st Eucharist?	Confirmation?
			Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N
			Y N	Y N	Y N	Y N

Over \_\_\_\_\_

# MEDICAL INFORMATION FORM

Student's Name \_\_\_\_\_

Parent/guardian \_\_\_\_\_ Phone Number \_\_\_\_\_

If you are unable to be reached in case of an emergency, whom should we call?

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Hospital preference \_\_\_\_\_

Student's physician \_\_\_\_\_

Physician phone no. \_\_\_\_\_

The following information is necessary in case we need to seek emergency treatment for your child. Your answers will be kept confidential to be used only in case of emergency.

Is your child allergic to anything? Medicines \_\_\_\_\_

Food \_\_\_\_\_ Animals \_\_\_\_\_

Trees, plants \_\_\_\_\_ Others \_\_\_\_\_

Does your child take any medications? \_\_\_\_\_

What medication? \_\_\_\_\_ To treat what condition? \_\_\_\_\_

Does your child have the following ..

Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_

Heart condition \_\_\_\_\_ High Blood pressure \_\_\_\_\_

Vision problems \_\_\_\_\_ Hearing problems \_\_\_\_\_

Can your child:

walk unassisted? \_\_\_\_\_

sit for moderate periods of time? \_\_\_\_\_

eat and drink unassisted? \_\_\_\_\_

take part in moderate physical activity? \_\_\_\_\_

I authorized emergency treatment to be administered to \_\_\_\_\_

I understand that every attempt will be made to reach me, but if the severity of the injury indicates the necessity, the emergency response system may be called.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_