



Saint Matthews Episcopal Church  
**Sunday School Registration Form 2011 – 2012**

Episcopal Children's Curriculum: Year of the Cross

Classes for ages Birth through 6<sup>th</sup> Grade  
 School runs August 21<sup>st</sup>, 2011 through May 20<sup>th</sup>, 2012  
 Lessons begin at 10:15 AM each Sunday

Check [www.stmattswv.com](http://www.stmattswv.com) regularly for up-to-date school information



Child's Name	Date of Birth	Age On Aug. 31	School Grade Sept. 2011	Baptized?
	/ /			YES / NO
	/ /			YES / NO
	/ /			YES / NO
	/ /			YES / NO

Home Address:	City	State	Zip
Home Phone:	(    )    -		
Email Address:			
Mother's Name & Cell #:	Name:	Cell Phone #:	(    )    -
Father's Name & Cell #:	Name:	Cell Phone #:	(    )    -
Emergency Contact:	Name:	Phone #:	(    )    -

Is your child allergic to Peanuts?	YES / NO	Is your child allergic to Tree Nuts?	YES / NO
Does your child(ren) have any other medical conditions or special needs that may affect his/her participation in Sunday School? If yes, please describe in detail the box below:			

Would you like to support our Sunday School Program? If so, please indicate how in the box below <input checked="" type="checkbox"/>			
Financial Support <input type="checkbox"/>	Be a Substitute Teacher <input type="checkbox"/>	Assist in a classroom <input type="checkbox"/>	Help with special events <input type="checkbox"/>
Help provide Healthy Snacks for Sunday School <input type="checkbox"/>		Help with Group Time 10:15 – 10:30AM <input type="checkbox"/>	
Other (please explain):			

Please note that Saint Matthews uses suitable photos, videos or other images of children participating in church activities and events for publicity and informational purposes. This includes but is not limited to: church notice boards, the church website and in our and diocesan publications. By registering your child, you agree to us using any images of your child in this way.

EMERGENCY MEDICAL AUTHORIZATION			
Saint Matthews Episcopal Church has my permission, in an emergency when I (or my physician) cannot be contacted, to seek emergency medical care at the nearest emergency room. The hospital and its medical staff have my authorization to provide any treatment, which a physician deems necessary for the well being of my child.			
Child's Physician:	Name:	Phone #:	(    )    -
Parental Signature:		Date:	/ /