



Saint Matthews Episcopal Church
Sunday School Registration Form 2009 – 2010

Episcopal Children's Curriculum: Year of the Shell

Classes for ages Birth through 6th Grade

School runs August 23rd, 2009 through May 23rd, 2010

Lessons begin at 10:15 AM each Sunday

Check www.matthew1893.org regularly for up-to-date school information



Child's Name	Date of Birth	Date of Baptism <i>(put X if not Baptized)</i>	Age On Aug. 31	School Grade Sept. 2009
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	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

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 Music 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 AUTHORISATION			
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:	/ /