

# RELIGIOUS EDUCATION REGISTRATION FORM

**St. Patrick – Arcola**

12305 Arcola Road  
Fort Wayne, IN 46818  
(260) 625-4151

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

(Last)

Cell Phone #: (260) \_\_\_\_\_ (260) \_\_\_\_\_

Home Phone #: (260) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Are you registered in the Parish? Yes \_\_\_\_\_ No \_\_\_\_\_

**Class starts Sept. 8, 2024**  
**Pre-K (must be at least four years of age)**  
**through Grade 12**  
**Class Time: Sundays**  
**(promptly) 8:30 a.m. – 9:45 a.m.**

**\*\*Student's Name:** \_\_\_\_\_ **D/O/B:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Allergies and/or Medical Concerns:** \_\_\_\_\_

Sacraments Received: ☐ Baptism ☐ Reconciliation ☐ Eucharist ☐ Confirmation  
(Check all that apply)

**\*\*Student's Name:** \_\_\_\_\_ **D/O/B:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Allergies and/or Medical Concerns:** \_\_\_\_\_

Sacraments Received: ☐ Baptism ☐ Reconciliation ☐ Eucharist ☐ Confirmation  
(Check all that apply)

**\*\*Student's Name:** \_\_\_\_\_ **D/O/B:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Allergies and/or Medical Concerns:** \_\_\_\_\_

Sacraments Received: ☐ Baptism ☐ Reconciliation ☐ Eucharist ☐ Confirmation  
(Check all that apply)

**\*\*Student's Name:** \_\_\_\_\_ **D/O/B:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Allergies and/or Medical Concerns:** \_\_\_\_\_

Sacraments Received: ☐ Baptism ☐ Reconciliation ☐ Eucharist ☐ Confirmation  
(Check all that apply)

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City, State

Zip Code

Child lives with: \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other

**Emergency contact name/number(s) not listed above:** \_\_\_\_\_

I am interested in volunteering: ☐ Weekly ☐ Occasionally

**REGISTRATION FEES:**

\*If you are in need of financial assistance, please contact the parish office at (260) 625-4151.

Please note that all calls regarding financial assistance will be kept confidential.

**One Child \$ 35.00**

**Two Children: \$ 70.00**

**Family Maximum: \$105.00**

**For Office Use Only:**

Paid: \_\_\_\_\_

Date

☐ Cash

Amount

☐ Check

Check No.