

**St. Francis Xavier**  
**Parish Religious Education Program (PREP)**  
**2010 – 2011 Student Re-Registration Form**

524 9<sup>th</sup> St., Wilmette, IL 60091  
 Phone: (847) 256-4250  
 Fax: (847) 256-4254  
 Website: <http://www.sfxparish.org>  
 Email: [sfxprep@comcast.net](mailto:sfxprep@comcast.net)

Please Print all Information  
 and Return by June 1

(If you will NOT be returning to PREP this fall please notify us at 256-4250 ext. 16)

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

**Family Information**

<u>Father</u>	<u>Mother</u>
Last Name: _____	Last Name: (if different from Father's) _____
First Name: _____	Maiden Name: _____
Religion: _____	First Name: _____
Work Phone: _____	Religion: _____
Cell Phone: _____	Work Phone: _____
	Cell Phone: _____

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Should additional mailing be sent to an alternate address?  Yes  No (If yes, please fill in below)

Name	Street	City	Zip	Phone

**Tuition Information** *(helps cover cost of books/supplies/program expenses)*

**\*Please note timeline for payment. Make checks payable to St. Francis Xavier.**

**Registered Parishioners**

One Child \$ 275.00 \_\_\_\_\_  
 Two Children \$ 380.00 \_\_\_\_\_  
 Three + Children \$ 500.00 \_\_\_\_\_

**Fees**

Reconciliation/First Eucharist  
**Grade 2** \$ 60.00 \_\_\_\_\_

Confirmation  
**Grade 8** \$ 60.00 \_\_\_\_\_

**Discount**

\$275.00 Waived for Catechist  
 in the program \$ \_\_\_\_\_  
 (150.00 if team teaching)

**Scholarship Donation**

PREP Scholarships \$ \_\_\_\_\_

**Total Due:** \$ \_\_\_\_\_

**Payment Enclosed:**

**Non-Registered Parishioners**

One Child \$ 300.00 \_\_\_\_\_  
 Two Children \$ 600.00 \_\_\_\_\_  
 Three + Children \$ 900.00 \_\_\_\_\_

**Fees**

Reconciliation/First Eucharist  
**Grade 2** \$ 60.00 \_\_\_\_\_

Confirmation  
**Grade 8** \$ 60.00 \_\_\_\_\_

**Total Due:** \$ \_\_\_\_\_

**Payment Enclosed:**

**\* If full payment is not included with this form, please check one:**

Pay first day of class:

Extended Payment Arrangements:   
 (3 Installments: Oct., Dec., Feb.)

Requesting Scholarship:

Please call us:

**OVER** →

**Student Information**

**Please Print**

PLEASE CHECK CLASS SESSION: \_\_\_ SUNDAY 9:00AM-10:10AM \_\_\_ MONDAY 4:15PM – 5:25PM

<u>Name</u>	<u>Nickname</u>	<u>Sex</u>	<u>Grade Level</u> (2010-2011)	<u>School Attending</u>	<u>Birth Date</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

\*Please let us know if you are requesting that your child be in the same room as a friend.

PLEASE CHECK:  Yes, you may use pictures of my child/ren in which they are not identified.  
 No, we ask that you do not use pictures . . . .

Child/ren live with: \_\_\_ Father \_\_\_ Mother \_\_\_ Both \_\_\_ Other

If one parent does not have legal access, please provide our office with the appropriate legal document.

**New Student Information**

<u>Name</u>	<u>Nickname</u>	<u>Sex</u>	<u>Grade Level</u> (2009-20010)	<u>School Attending</u>	<u>Birth Date</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Sacrament(s) Received (✓):  BAPTISM  RECONCILIATION  EUCHARIST  CONFIRMATION  
 Approximate Date: \_\_\_\_\_  
 Parish/City: \_\_\_\_\_

If your child was not baptized at St. Francis Xavier, please enclose a copy of your child's baptismal certificate with this form.  Baptismal certificate enclosed.

**Authorization for Medical Treatment – September 2010 – May 2011**

In the event that the undersigned, or my (our) authorized physician, cannot be reached, and in the judgment of the Director of Religious Education or other appropriate staff member there is a necessity for immediate examination and/or treatment of my (our) child/ren, I (we) hereby authorize any of the aforesaid personnel to obtain for my (our) child/ren named above such medical services as are deemed necessary.

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Insurance Number: \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature Date

\_\_\_\_\_  
Parent's Signature Date

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Special needs: My child has a special medical condition or other need of which the Program Administrator and his/her teachers should be aware:

Name of Child: \_\_\_\_\_

Special Need(s): \_\_\_\_\_