# *St. Patrick Parish Faith Formation* Returning Student Update

STUDENT NAME _____

*Dear Parent: Please indicate "No Changes" or "Changes" for each returning child and be sure to sign and date each entry. A completed form is required each year for each returning student.*

**Grade 2** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

**Grade 3** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

**Grade 4** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

**Grade 5** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

**Grade 6** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

**Grade 7** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

**Grade 8** ☐ No Changes ☐ Changes noted below
Address/Phone Corrections _____

Other _____

_____ _____ _____
*Parent Signature* *Date* *School Year*

Office Use Only
Tuition Paid _____
Check # _____ Initial _____

Student Name: Last First

**IN AN EMERGENCY, PLEASE CONTACT IN THIS ORDER:**

1. _____
   Telephone(s) Name PARENT (S)

2. _____
   Telephone(s) Name Relationship to student

3. _____
   Telephone(s) Name Relationship to student

Student has responsible party's permission to be picked-up by:

- _____
- _____
- _____

Student Health Issues, Allergies, Special Needs (Please be specific)

_____

_____

_____

Primary Physician: _____
Name Telephone

Other: _____

_____

_____

Responsible Party Signature: _____

Date: _____