|  |  |  |
| --- | --- | --- |
|  | Head of Household | Spouse |
| Title: (Circle One) | Mr. Mrs. Miss Ms. Dr. Rev. Other\_\_\_\_\_\_\_\_\_\_\_\_ | Mr. Mrs. Miss Ms. Dr. Rev. Other\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: (First Middle (Maiden) Last) |  |  |
| Sex: | Male 🞏 Female 🞏 | Male 🞏 Female 🞏 |
| Birthday: |  |  |
| Preferred Name/Nickname: |  |  |
| NOTE: For information below, please check the box if we can include it in the directory. |
| Address:City, State/Zip: | 🞏 |
| Primary Phone: | 🞏 | 🞏 |
| Secondary Phone: | 🞏 | 🞏 |
| Family Email:This will be the primary communication from First Lutheran. | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| Name (first, middle, last) | Birth Date | Grade(2019-2020) | Baptized |
| 1. | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Cell Phone 🞏 | School | Confirmed |
|  |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Allergies: |  |
| Name (first, middle, last) | Birth Date | Grade(2019-2020) | Baptized |
| 2. | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Cell Phone 🞏 | School | Confirmed |
|  |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Allergies: |  |
| Name (first, middle, last) | Birth Date | Grade(2019-2020) | Baptized |
| 3. | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Cell Phone 🞏 | School | Confirmed |
|  |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Allergies: |  |
| Name (first, middle, last) | Birth Date | Grade(2019-2020) | Baptized |
| 4.  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Cell Phone 🞏 | School | Confirmed |
|  |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Allergies: |  |
| Name (first, middle, last) | Birth Date | Grade(2019-2020) | Baptized |
| 5. | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Cell Phone 🞏 | School | Confirmed |
|  |  | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Allergies: |  |