FAITH FORMATION REGISTRATION
St. John the Baptist-ARCADIA
2018 – 2019

Parent(s) Responsible for child: _____
Address_____ City_____ ZIP_____
Home Phone_____ Cell Phone-father _____ Cell Phone-mother _____
Father's work phone _____ Mother's work phone _____
E-mail is used only to notify you of cancellations or other important information. Please put only the ones you want to use in those circumstances.
Home E-mail _____ Father's Work E-mail _____ Mother's Work E-mail _____
EMERGENCY CONTACT: Please give us the name of a friend or relative we could contact if we are unable to reach you in an emergency.
Name_____ Phone_____ Relationship_____

Child's First Name												
Child's Last Name												
School Grade 2018-2019												
School Name												
Date of Birth												
Male / Female (circle one)	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Baptized (circle one)	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Received 1st Reconciliation	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Received 1st Communion	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Received Confirmation	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Any Physical or Learning Disabilities												

I/We hereby consent to the participation of my/our child(ren) in the parish Faith Formation program held at the parish checked above.

I understand this program will take place on parish property under the supervision of parish staff and volunteers. (Additional permission will be needed for any activities, which will take place off parish property [i.e. field trips].) As a parent (or legal guardian) I remain fully responsible for any legal responsibility that may result from any personal actions taken by my child(ren).

Parent/Guardian_____ Date_____

FEES:

$25 – 1 child	**Catechist** $0.00 – 1 or more children
$35 – 2 children	
$50 – 3 or more -Maximum Fee Per Family	

Total Amount Due:
Total Amount Paid: Cash Check #
Balance Due:

Please complete both sides of form

PARENTAL/GUARDIAN CONSENT FORM AND LIABILTY WAIVER
MEDICAL MATTERS

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child(ren) is/are in good health, and I assume all responsibility for the health of my child(ren). **(Of the following statements pertaining to medical matters, sign only those that are applicable.)**

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child(ren) to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & relationship:_____Phone: _____

Family Doctor: _____Phone: _____

Family Health Plan Carrier: _____Policy #: _____

Signature: _____Date: _____

Other medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Sioux City, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature:_____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are listed below.

Signature:_____ Date: _____

No medication of any type whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature:_____ Date: _____

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The parish/school will take reasonable care to see that the following information will be held in confidence.

Child's First Name												
Child's Last Name												
Medically Prescribe Diet	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Physical Limitations	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
If yes to above, list date & disease/condition												
You should be aware of these special medical conditions of my child												
Medications (dosages/frequency)												

Signature:_____ Date:_____

Please complete both sides of form