2019-2020
Date Registered:_______________________

CHURCH OF THE NATIVITY
Faith Formation Preschool-12
2019-2020 **Registration Form**

Date ____________________

FAMILY LAST NAME __________________________________ HOME PHONE #__________________________

ADDRESS______________________________________ CITY AND STATE ____________________________ ZIP CODE____________

FATHER'S NAME _________________________WORK PH# ______________Cell PH#____________ FATHER'S RELIGION___________

Father's Email Address: ____

MOTHER'S NAME _________________________WORK PH# _______________Cell PH#___________ MOTHER'S RELIGION___________

Mother's Email Address: ____

Are either of you interested in helping in the Faith Formation program? ______ If yes, in what capacity? ________________________

<u>Attention:</u> please circle your choice of Sunday or Wednesday Family Faith Formation

CHILD'S INFORMATION (***Include Last Name if different from Family Name***) Preschool children must be 4 years old by September 1st

	FIRST NAME	BIRTHDATE	GRADE	SCHOOL	Baptized	Reconciliation	Eucharist	Confirmed
1.								
2.								
3.								
4.								

Please indicate any medical information, food allergies, etc. about your child which we should be aware:________________________

<u>**$10 discount on total amount of registration fees if paid by July 1st**</u>

<u>Faith Formation Registration Fees</u>:

Starting July 1st
$60.00 for one child
$100.00 for two children
$130.00 for three children
$150.00 for four or more children

<u>Sacramental Fees</u> :
(students must also attend Faith Formation classes or Catholic School)
$100.00 for Reconciliation/Eucharist Programs (2nd grade or older)
$100.00 for Confirmation Program (9th grade or older)

Paid: $______________Check #_____________

Diocese of Orlando

OFFICE OF YOUTH & YOUNG ADULT MINISTRY •
PARENTAL/GUARDIAN CONSENT FORM, LIABILITY WAIVER & MEDICAL CONSENT

please PRINT legibly

Medical Matters

I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign/initial only those in accordance with your wishes:

Emergency Medical Treatment

In the event of an emergency, I hereby give permission to transport my child to a hospital/clinic for emergency medical or surgical treatment.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship ____________________________________ Phone _____________________________

Family Doctor ____ Phone _____________________________

Medications

_____ I hereby **Grant Permission** for my child to be given the following provided medications. My child will bring all such medications, well labeled. [NOTE: Any/all prescription medications must be in original pharmacy container with young person's name on the prescription label. Non-prescription/over-the-counter medications must be in original container with young person's name on the container.] (*Please initial)*

Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

Medication: ___________________Dosage: _______________ Administer: ____

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Medication: ___________________Dosage: _______________ Administer: ____

Medical Conditions Information: (Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter:

Is allergic to the following medications ____

Has had an episode of the following or has been diagnosed with: ” Seizures ” Asthma ” Diabetic

Has had allergic reactions to the following (foods, dyes, latex, etc.)____

Has had a medical surgery within the last six months? ” Yes ” No Still under doctor's care? ” Yes ” No

Has a medically prescribed diet (*please explain*) ____

Has the following physical limitations____

Immunizations current and up to date? ” Yes ” No Date of last tetanus/diphtheria immunization____________________

You should also be aware of these special medical conditions of my child: ____

____

Insurance Information ” **No, I do not carry medical insurance at this time.**

Insurance Carrier: ______________________________________ Name of Insured: __________________________________

Insurance Policy Number: ____

Father's Name: ____ Day Phone: ________________________________

Mother's Name: ____ Day Phone: ________________________________

In the event the participant does not have insurance, payment in full for medical care becomes the responsibility of the participant's parent/guardian.

I fully understand the foregoing statements and sign this Parental/Guardian Consent Form, Liability Waiver & Medical Consent knowingly, freely, and willingly.

____ __________________________________

Parent/Guardian Signature *(must sign for any participant under 18 &/or 18 or older & in high school)* Date