

St. Kenneth Catholic Community

Confirmation Program Registration

2020-2021

Date: _____

Family Name _____

E-Mail Address: _____

Address _____

Father's Name _____

City/Zip _____

Mother's Name _____

Home Phone _____

Single Parent Home No ___ Yes ___

Cell Phone (M) _____

Child resides with _____

Cell Phone (F) _____

Emergency Contact: _____
(other than parents)

Phone: _____
Phone: _____

<div style="border: 1px solid black; padding: 5px; width: 80%; margin: auto;"> <p>Parent Volunteer Opportunity</p> </div>	<div style="border: 1px solid black; padding: 5px; width: 90%; margin: auto;"> <p><u>Table Mentor</u></p> <p>Name: _____</p> </div>
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PLEASE BE AWARE: A Mask IS required to enter the building. The pandemic is not over and guidelines will be enforced in order to protect the health and safety of everyone in our community.

STUDENT'S FULL NAME

SCHOOL NAME

Name _____

School _____

Special Needs: medical, learning disabilities, allergies.. _____

Name _____

School _____

Special Needs: medical, learning disabilities, allergies.. _____

PLEASE PROVIDE A COPY OF YOUR CHILD'S BAPTISM CERTIFICATE IF HE/SHE WAS NOT BAPTIZED AT SAINT KENNETH

During the course of the year, we may take pictures that involve your child. May we put these pictures in the church bulletin and/or on our website? No names will be listed. ___ Yes ___ No Signature: _____

Registration Fee: \$80.00 per child

Checks payable to: **St. Kenneth Faith Formation**

Amount Paid: _____ Check here to bill later: _____

OFFICE USE ONLY
DATE: _____

AMOUNT PAID: _____

CHECK/CASH # _____

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____ City: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medication, contract, or other pertinent comments:

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____

Signed: _____
(Parent or Guardian)



Confirmation Calendar 2020-2021

September 30, 2020 – Parent Meeting at 7:00 pm

October 14, 2020 – Class 6:30 pm to 8:00 pm

October 28, 2020 – Class 6:30 pm to 8:00 pm

November 4, 2020 – Class 6:30 pm to 8:00 pm

November 18, 2020 – Class 6:30 pm to 8:00 pm (Sponsor Night/Enrollment Ceremony)

December 9, 2020 – Class 6:30 pm to 8:00 pm

January 6, 2021 – Class 6:30 pm to 8:00 pm

January 20, 2021 – Class 6:30 pm to 8:00 pm

February 3, 2021 – Class 6:30 pm to 8:00 pm

Confirmation Mass: TBD

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