Saint Kenneth Catholic Community
Confirmation Program Registration
2021-2022

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: _____ Phone: _____
(other than parents) _____ Phone: _____

Parent Volunteer Opportunity

Table Mentor

Name: _____

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: ***Saint Kenneth Faith Formation***

Amount Paid: _____ Check here to bill later: _____

OFFICE USE ONLY
DATE: AMOUNT PAID: CHECK/CASH # _____

5/4/21

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)