SANTA MARIA DEL MAR
FAITH FORMATION

Pre-K thru 12th Grade
ENROLLMENT FORM

Date: 2019-20 School Year

The Lamp (Pre-k- 5) Grade: _____ **Children's Choir**(1-8)_____**Light** (6-8) Grade: _____**Life Teen** (9-12) Grade: _____

Tuition: **$65 (1st child) _____ $55 (2nd child)_____ $45 (other children) _____ Total:_____**

Cash:$_____ Check #:_____ Amt $_____ **Payment Plan: _____ Family #:_____**

Child's Name_____ Birth Date: _____Gender _____

Address:_____City/ST/Zip:_____

Home Phone #:_____ Cell Phone #:_____

Mother's Email:_____ Father's Email:_____

Emergency Contact Name & Phone:_____

Release Statement – I hereby grant permission for my child to be photographed during Santa Maria del Mar Faith Formation group activities for use in the church bulletin. **Please initial:_____**

A copy of your child's Baptismal, Communion and Confirmation Certificate *MUST* be attached if not on file.

Baptism Date: _____ Church Name:_____

Address: _____

Communion Date_____ Church Name: _____

Address _____

Confirmation Date:_____ Church Name: _____

Address:_____

Father's Name:_____ Religion:_____

Occupation:_____ Cell Phone #:_____

Mother's Name:_____ Religion:_____

Occupation:_____ Cell Phone #:_____

Parents are: married____ separated____ divorced____ remarried____ annulled____ widowed_____

Child lives with:_____ Student's School:_____

Diocese of St. Augustine

Parent/Guardian Medical Release Form

Child's Name:_____Date of Birth:_____

Parent/Guardian Name:_____

Home Address:_____

Home Phone:_____Cell Phone:_____

Name of Diocesan Entity:_____SANTA MARIA DEL MAR_____

MEDICAL MATTERS: I hereby warrant that 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 only in accordance with your wishes.)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to the above names Diocesan entity's employees, volunteers or representatives to seek medical treatment for my child names above.

In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name and Relationship_____Phone_____

Family Doctor_____Phone_____

Family Health Plan Carrier_____Policy #_____

I make the following exceptions_____

Medication_____Dosage_____Doctor_____

Medical Problem or Condition (allergies,diabetes)_____

Condition_____Symptoms_____

Physical Disabilities_____

_____ _____

Signature of Parent/Guardian Date

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the above names Diocesan entity's volunteer or representative, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

_____ _____

Signature of Parent/Guardian Date