Santa Maria del Mar Life Teen

8th Grade - 12th Grade
Registration Form

2021-2022

Grade 8: _____Grade 9_____Grade 10: _____Grade 11: _____Grade 12: _____Jr. Core: _____ Core: _____

Donation: $_____

Cash:$_____ Check #:_____ Amt $_____ Monthly: _____ Family #:_____

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 Life Teen group activities for use in the church bulletin, social media and church web-site **Please initial:_____**

It is helpful to have a copy of your teen's records in our church files.

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_____

Teen lives with:_____ Teen's School:_____

Diocese of St. Augustine

Parent/Guardian Medical Release Form

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 teen named 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 teen 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**