

Parish \_\_\_\_\_

Family Name \_\_\_\_\_

## St. Agnes/St. Cecilia Religious Education Registration

*One form per child please*

### **Family Information:**

Last Name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Mother's maiden name: \_\_\_\_\_

Single parent home? Yes \_\_\_ No \_\_\_ Child resides with: \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_

Zip code: \_\_\_\_\_ Phone number(s) \_\_\_\_\_

### **Student Information**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_

Please indicate if there are any medical conditions, food allergies/restrictions, or learning issues:

\_\_\_\_\_  
\_\_\_\_\_

Baptism: Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, where: \_\_\_\_\_

Received first Eucharist: Yes \_\_\_\_\_ No: \_\_\_\_\_

Received Confirmation: Yes: \_\_\_\_\_ No: \_\_\_\_\_

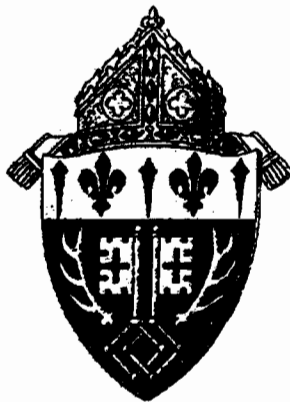
### **Emergency Contact Information**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Please print signature: \_\_\_\_\_



## EMERGENCY MEDICAL TREATMENT RELEASE FORM

(Recommended Form)

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger the life of the student, cause a disfigurement, physical impairment, or undue discomfort if delayed. 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 \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

List allergies, medication, contacts, or other pertinent information:

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Data:

Company \_\_\_\_\_ Policy \_\_\_\_\_

Group \_\_\_\_\_ Contract \_\_\_\_\_

This Release Form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date \_\_\_\_\_ Signed \_\_\_\_\_

(Parent or Guardian)



## Photo/Recording Release

### **Adult**

I give permission for any photograph, video, audio recording and/or likeness procured of myself to be used by the Diocese of Marquette. These may be used for promotional purposes and reproduction in any type of media form. I understand and agree that the use of my photograph, video or audio recording, and/or likeness is not an invasion of privacy. Neither I nor anyone claiming to be speaking on my behalf will object to the Diocese of Marquette using this material.

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Signature

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Date

### **Parent/Guardian**

I give permission for any photograph, video, audio recording and/or likeness procured of my child(ren) \_\_\_\_\_ to be used by the Diocese of Marquette. These may be used for promotional purposes and reproduction in any type of media form. I understand and agree that the use of their photograph, video or audio recording, and/or likeness is not an invasion of privacy. Neither I nor anyone claiming to be speaking on my behalf will object to the Diocese of Marquette using this material.

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Parent/Guardian signature

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Date