

# Faith Formation Registration 2024-25 Pre-School

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Family Name: \_\_\_\_\_  
Registered in Parish? (Y/N) \_\_\_\_\_ If N, with which parish are you registered? \_\_\_\_\_  
Address: \_\_\_\_\_

Father/Guardian: Name \_\_\_\_\_ Work # \_\_\_\_\_  
Cell # \_\_\_\_\_ Texting Available? (Y/N) \_\_\_\_\_  
Email Address (this is checked frequently) \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_

Mother/Guardian: Name \_\_\_\_\_ Work # \_\_\_\_\_  
Cell # \_\_\_\_\_ Texting Available? (Y/N) \_\_\_\_\_  
Email Address (this is checked frequently) \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_

Child's First Name	DOB	School	Grade	Baptism Date & Church
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list which children have received the Eucharist, including date and parish  
\_\_\_\_\_

Please list which children have received Confirmation, including date and parish  
\_\_\_\_\_

Do children live with one or both parents? \_\_\_\_\_ If so, which one? \_\_\_\_\_  
Should communication be sent to both parents? \_\_\_\_\_  
Did your child/children attend a Faith Formation program last year? (Y/N) \_\_\_\_\_ If so, where? \_\_\_\_\_

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**Faith Formation for ages 3-4-5 will meet twice a month on the 2nd and 4th Sunday of the month during the 10:00 AM Mass.**

**There is no cost for this program. Please register to allow us to prepare enough materials for classes.**

**Check here if you would like more information on Children's Liturgy of the Word during 11:30 AM Mass**

+ For information on registering for Faith Formation or sacrament prep for grades 1-8, please visit [saintadalbertparish.org/faithformation](http://saintadalbertparish.org/faithformation) or contact Gina at [familyfaithformation@saintadalbertparish.org](mailto:familyfaithformation@saintadalbertparish.org).

+ Are you interested in learning more about the faith or are you or someone you know, interested in becoming a member of the church, contact the office. 440-234-6830 x 100 or visit [http:// www.saintadalbertparish.org/interested-in-becoming-catholic/](http://www.saintadalbertparish.org/interested-in-becoming-catholic/)

Please return form to: St. Adalbert Religious Education Office by August 10th, 2024.  
66 Adalbert Street,  
Berea, OH 44017

Questions: Contact Gina Cepelnik at 440-234-6830 or [familyfaithformation@saintadalbertparish.org](mailto:familyfaithformation@saintadalbertparish.org)

**EMERGENCY MEDICAL AUTHORIZATION**

NAME \_\_\_\_\_  
Last \_\_\_\_\_  
First \_\_\_\_\_

\_\_\_\_\_  
Student Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
Phone Number

**Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**PART I OR II MUST BE COMPLETED  
PART I TO GRANT CONSENT**

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number or \_\_\_\_\_ (other parent or guardian) at \_\_\_\_\_ (phone number) have been unsuccessful, I hereby give my consent or: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred physician) or Dr. \_\_\_\_\_ (preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Signature of Parent or Guardian  
\_\_\_\_\_  
Address

**DO NOT COMPLETE PART II IF YOU COMPLETED  
PART I PART II REFUSAL TO CONSENT**

I do not give my consent for emergency medical treatment of my child, in the event of illness or injury requiring emergency treatment, I wish the parish authorities to take no action or to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Signature of Parent or Guardian  
\_\_\_\_\_  
Address

BIRTHDATE \_\_\_\_\_

# St Adalbert Faith Formation Program

## Media Consent and Release Form

I (We) the parent(s) and/or guardian(s) of the minor child identified below hereby grant St. Adalbert Parish (“Parish”) and/or its agents consent to record (in writing or otherwise), photograph, audiotape, or videotape my minor child’s name, image, likeness, spoken words, schoolwork or school projects, in any form, and to display, release, exhibit, publish, or distribute the same, or any part thereof, for any lawful school or Parish use or purpose including, without limitation, use on the Parish’s bulletin boards, websites, social media sites, print and electronic media, marketing publications, public relations and communications materials and/or presentations, and any other uses as may not be contemplated herein, without further notice or compensation as follows:

I consent.

I do not consent.

I further understand that by entering into this informed consent and release, and by granting permission as stated herein, I hereby release the Parish, the Diocese of Cleveland, the Bishop of Cleveland, and their respective officers, directors, agents, employees and/or attorneys from and against any and all liability, loss, damage, costs, claims, and/or causes of action arising out of or related to the above items to which I have consented.

I further understand that the Parish and its respective officers, directors, agents, employees and/or attorneys have no control over use of photographs, videotapes, audiotapes, or other records made by others and/or outside the scope of this consent and release.

Finally, in signing below I acknowledge that all recordings, audiotape, videotape, photographic proofs, photographic negatives, positives, and prints created pursuant to this Release shall constitute the sole property of the Parish.

\_\_\_\_\_  
Name of Minor Child (please print)

\_\_\_\_\_  
Signature of Parent(s) or Legal Guardian(s)

\_\_\_\_\_  
Name of Minor Child (please print)

\_\_\_\_\_  
Printed Name of Parent or Legal Guardian

\_\_\_\_\_  
Name of Minor Child (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Minor Child (please print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State & Zip