Faith Formation Registration 2024-25 Youth Group

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? _____

Please return form to: St. Adalbert Faith Formation by August 10th, 2024
66 Adalbert Street,
Berea, OH 44017

Questions: Contact Gina Cepelnik at 440-234-6830 x 103 or familyfaithformation@saintadalbertparish.org
Or email Jodi at saym@saintadalbertparish.org

EMERGENCY MEDICAL AUTHORIZATION

NAME _____
Last First

_____
Student Name

_____
Address

_____
Phone Number

BIRTHDATE _____

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 Il 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 Il IFYOU COMPLETED

PART I PART Il 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

MU-SSM-12
Rev. 1985

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