All Saints Parish
Youth Ministry
Student Registration Form

(Please Print)

STUDENT'S NAME_____DOB_____ GRD____ SCHOOL_____

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STUDENT'S NAME_____DOB_____ GRD____ SCHOOL_____

ADDRESS_____

Street City Zip

Student's e-mail _____Parent's email_____

We sometimes use email for our correspondence. When filling in the email address requests above, **please only give addresses that are viewed regularly.**

Home Phone # _____Student's Cell phone# _____

Parents Name(s) _____

Parents Cell #(s) _____

(Name and Number) (Name and Number)

Best way to contact students and parents about youth group: home phone, email, cell, text, facebook

Student_____Student_____Student_____Student_____

Parents_____

Any Special dietary needs? _____

Food Allergies? _____

Emergency Contact Person and phone number (additional-other than names and numbers listed above)

Name _____Phone _____cell _____

Additional Information we should know about: (Medical info should be listed on the Medical Release Form)

Media/Promotions Release: I give permission for All Saints Parish and the Diocese of Gaylord to use pictures taken at this event for promotional purposes. No names will be used with these pictures. It is my understanding that my signature releases the Diocese of Gaylord and All Saints Parish from any financial or legal responsibility for the use of this media relations/promotional materials.

Parent or Guardian signature: _____Date:_____

All Saints Parish Medical Treatment Release Form

To whom it may concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed physician in an emergency which, in the opinion of the attending physician, is deemed necessary and appropriate. This authority is granted only after reasonable effort has been made to reach me.

List all students covered by this release:

Student Name: _____Relationship to you:_____ Grade:____

Student Name: _____Relationship to you:_____ Grade: ____

Student Name: _____Relationship to you:_____ Grade: ____

Reason for which intended: Authorizes medical treatment under emergency circumstances in the absence of parent/guardian from **8-1-23 through and including 8-31-24**

Address of student: _____ Phone: _____
Emergency Phone: _____

Family Physician: _____ Phone: _____
Address: _____ City: _____

List Allergies, medication, contacts, or other pertinent comments: **Include student's name if multiple students are covered by this release.**

Health Insurance Data:

Company: _____ Policy: _____
Group: _____ Contract: _____

Does this policy apply to all students? ____yes _____no (If no, please provide info on reverse side)

I further authorize the person who presents the student to sign the Acknowledgment of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility.

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:_____

MCC:MEDAUTH 2/04 (Parent or Legal Guardian)