Catholic Community of the Blessed Trinity Faith Formation Registration, Grades 1-12 2015 - 2016

Family last name:					
Mother's (Maiden) name: _	(First)	(1.5.5)		Cell phone #:	
	(FIISL)	(Las	L)		
Father's name:				Cell phone #	
(First)		(Las ⁻	t)		
Primary address:				Home phone #:	
(Stre	et) (Tov	vn)	(Zip)	I I I I I I I I I I I I I I I I I	
Email address:					
				Grade (Sept. '15):	
Dentiens					
Baptism:(Year)		(Church wh	ere baptized)		
· · ·			- /		
Please indicate, by placing year. Information about pa			:(s) you would li	ke this child to celebrate in the	coming
First Reconciliation	First Eucharist	Confirm	nation		
Please list any allergies, die	etary restrictions, or o	other informatio	n you believe w	e should know about your child	:
Child's name:		Age:	DOB:	Grade (Sept. '14):	
Baptism:					
(Year)	(Month)	(Church wh	ere baptized)		
Please indicate if you would parent meeting will be sent				coming year. Information about irst Eucharist.	t
First Reconciliation	First Eucharist	Confir	nation		
Please list any allergies, die	etary restrictions, or o	other informatio	n you believe w	e should know about your child	:
Child's name:		Age:	DOB:	Grade (Sept. '14):	
Baptism:					
Baptism:(Year)	(Month)	(Church wh	ere baptized)		
Please indicate if you would parent meeting will be sent		•	• •	coming year. Information about irst Eucharist.	t
First Reconciliation	First Eucharist	Confirm	nation		
Please list any allergies, die	etary restrictions, or o	other informatio	n you believe w	e should know about your child	:

EMERGENCY CONTACTS ~ used only if parent cannot be reached in the event of an emergency.

#1 Name:	Relationship:		
Address:	Phone #:		
#2 Name:	Relationship:		
Address:	Phone #:		

PART 1 HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED CHILD/CHILDREN

Insurance company or other program:	
Family Physician Name & Phone #:	
Hospital preferred:	

I/We, being the parent(s) or legal guardian(s) of the above named child/children, appoint the designated parish faith formation facilitator to act in my/our behalf in authorizing necessary emergency medical, dental, surgical care, and hospitalization necessary to protect the child's life or health while he/she is participating in any parish faith formation activity occurring September 14, 2014 through May 17, 2015.

Signature of Parent/Guardian: ____

Date:

PART 2 REFUSAL TO CONSENT (COMPLETE THIS PART ONLY IF YOU DO NOT CONSENT TO EMERGENCY TREATMENT

I DO NOT give my consent for emergency medical treatment of my child/children. In the event of illness or emergency treatment being required, I wish the Faith Formation authorities to take **NO ACTION** or to follow these instructions:

AUTHORIZATION FOR PHOTO RELEASE

We love to highlight our children and their families when we have our faith formation events. We appreciate the opportunity to use photographs on our website, Facebook page, and bulletins from time to time. Please check (yes or no)

YES! I do consent to the use and reproduction of photography taken during Faith Formation Activities in which my child/children are reasonably identifiable.

NO! I do not consent to the use of any photography in which my child/children are reasonably Identifiable.

Would you be w	illing to help i	n some way in our	faith formation	program? (Circle)	Y	or	Ν
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Signature of Parent/Guardian	D	Date:
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Return by mail (Attention: Corey Ginnet, 11956 Washington St. Wolcott, NY 14590) or by Sunday collection basket.