Last name_____

St. Kenneth Parish
Children's Faith Formation Program (CFP) 2017-2018
Grades 1-5

Parent information

Mother's name _____ cell # _____ e-mail _____

Father's name _____ cell# _____ e-mail _____

Home Address _____

Class Registration: Monday 5-6:15 ☐ **Tuesday 5-6:15** ☐

Student 1 Last Name _____ First Name _____

Date of Birth _____ Grade in fall 2018 _____ School Name _____

Please list any medical conditions, food allergies, physical limitations and or academic challenges below:

_____

Student 2 Last Name _____ First Name _____

Date of Birth _____ Grade in fall 2018 _____ School Name _____

Please list any medical conditions, food allergies, physical limitations and or academic challenges below:

_____

Student 3 Last Name _____ First Name _____

Date of Birth _____ Grade in fall 2018 _____ School Name _____

Please list any medical conditions, food allergies, physical limitations and or academic challenges below:

_____

Tuition: $80 per child (Please make checks payable to St. Kenneth Faith Formation)

IMPORTANT: Your family must be registered in the parish

Photo Permission: I release St. Kenneth parish of any and all liability and give permission to have pictures of my family/child on the St. Kenneth web-site and in the church bulletin: Yes ☐ No ☐

Emergency contact: Name _____ Phone number _____
(other than parent) Relationship to child _____

Parent Signature _____ **Date** _____

Office Use: Date _____ **Amount Paid** _____**Check/Cash** _____

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. 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: _____ City: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medication, contract, or other pertinent comments:

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

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

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ Signed: _____

(Parent or Guardian)

PSI/MedRel/05-94

HAPS-March 2004