Last name_____

# Saint Kenneth Parish

## Children's Faith Formation Program (CFP) 2018-2019

### Grades 1-5

**Parent information**

Mother's name _____ phone # _____ e-mail _____ (please print clearly)

Father's name _____ phone # _____ e-mail _____ (please print clearly)

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 Saint Kenneth Faith Formation)**

**IMPORTANT: Your family must be registered in the parish**

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

Emergency contact: Name _____Phone number _____ Relationship to child_____

**Parent Signature** _____ **Date** _____

***I have a child making their First Communion this year YES** ☐ **NO** ☐
***If you have a child making their First Communion please be sure to fill out a First Communion registration form.**
****I have a child making Fourth Grade Reconciliation this year YES** ☐ **NO** ☐
****If you have a child making their Fourth Grade Reconciliation please be sure to fill out a Reconciliation registration form.**

**Please fill out the REQUIRED Medical release form on the back of registration form.**

**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)

CFP Parents-

There is always a need for assistance in the CFP program. We are in need of catechists, assistants, hall monitors, nursery coverage, and substitutes. I would ask that you consider volunteering for one of these positions. All lesson plans and materials are provided.

We are especially in need of catechists and assistants, as well as substitutes. Please indicate below if you would be willing to assist.

*Catechist ____
*Assistant catechist ____
Hall Monitor ____
Nursery ____
*Substitute catechist ____

Thank you in advance.

**As catechists, you would need to submit a background check form (yearly)and attend a Protecting God's Children workshop (only once).

Name_____

Email_____

Cell Phone_____ Home Phone_____