**Youth Group REGISTRATION 2024 – 2025**

**CATHOLIC COMMUNITY OF Holy Family, Sacred Heart, St. Alphonsus and St. Ann Faith Formation Office, 90 MElrose Rd, Auburn, NY 13021**

**Phone 315-252-7271, email: Barbara.Quinn@dor.org**

**Student First and Last Name** **Date of Birth** **Grade** **School**

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**Parents’ Names**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Church\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address, City and Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Numbers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INFORMATION:**

**Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any allergies, medical conditions or special needs your children have:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DISMISSAL INFORMATION:** Is there anyone to whom your children MAY NOT be released?

**PHOTO RELEASE:** I grant permission to Holy Family Church to use my children’s photos, images or likenesses in any media including websites.

**Please check one: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_**

**CERTIFICATION:** I hereby certify that the above information is correct. I grant permission for my children to be transported in privately owned vehicles for medical and other emergency purposes only, and for the release of medical records to an attending physician in case of illness. In case of medical emergency, I understand that every effort will be made to contact the parents or guardians. In the event that I cannot be reached, I hereby give permission to the physician on call to secure proper treatment for my children named herein.

I agree to adhere to the rules listed in the Faith Formation Handbook and Covenant.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian

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Printed Name of Parent/Guardian

Office Use Only: Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amt. Paid\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Form of Payment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fee is $30 per candidate and checks can be made out to Sacred Heart**