

FAITH FORMATION REGISTRATION

St. Francis of Assisi Church, 6245 Wilmington Pike, Centerville, Ohio 45459 937-433-0128 Ext. 206

Family's Last Name _____

Street Address _____

City _____ Zip Code _____

Home Phone (____) _____ Unlisted? Y N Family E-mail _____

Parish where your family is registered: _____

(Please include maiden name if applicable)

Parent/Guardian _____ Parent/Guardian _____

Religion _____ Religion _____

Cell Phone _____ Cell Phone _____

Work Phone _____ Work Phone _____

Volunteer area _____ Volunteer area _____

PARENT/GUARDIAN SIGNED AGREEMENT

I have read, understand, and accept the terms specified in the current Faith Formation Handbook on the St. Francis of Assisi website (sfacc.org).

Parent/Guardian Signature Date _____

Check here to request a Scholarship: (Available to registered parishioners)

STUDENT REGISTRATION

September 2017 – May 2018

Student Name _____ Grade for 2017/18 _____ Sex _____

Birth Date ____/____/____

Sacraments received: (check all that apply) Catholic Baptism non-Catholic Baptism

First Communion Reconciliation Confirmation

Session Choice: Day _____ Time _____ Home School _____

School Attending in 2017/18 _____

Student Name _____ Grade for 2017/18 _____ Sex _____

Birth Date ____/____/____

Sacraments received: (check all that apply) Catholic Baptism non-Catholic Baptism

First Communion Reconciliation Confirmation

Session Choice: Day _____ Time _____ Home School _____

School Attending in 2017/18 _____

Student Name _____ Grade for 2017/18 _____ Sex _____

Birth Date ____/____/____

Sacraments received: (check all that apply) Catholic Baptism non-Catholic Baptism

First Communion Reconciliation Confirmation

Session Choice: Day _____ Time _____ Home School _____

School Attending in 2017/18 _____

ACTIVITY INFORMATION

Church Agency: St. Francis of Assisi

Program: Faith Formation Program

Starting Date: September 2017

Ending Date: May 2018

Routine Activities: Faith Formation Classes

Usual Location: St. Francis of Assisi Parish

Usual Day and Time: Gr. 6-8 @ Mon 7-8:30 pm, Gr. 1-8 @ Wed 4:15-5:45 pm;

Winter Session Gr. 1-5 @ Sat 9:30 am-12:30 pm, Gr. 1-8 @ Sun 9:45-10:55 am, Home School, Sr. High FOCUS-Sun 6:30-8:30pm, Thurs 6:30-8:30

Coordinator of Elementary Faith Formation: Sylvia Carmody

Telephone No. 433-0128, ext 209 **Email:** scarmody@sfacc.org

Coordinator of Jr. High Faith Formation: Phyllis Wilemaitis **Telephone No.** 433-0128, ext 220 **Email:** pwilemaitis@sfacc.org

Coordinator of Sr. High Faith Formation: Marty McClain **Telephone No.** 433-0128, ext 204 **Email:** mmclain@sfacc.org

Check here if any additional information is attached. Note: any additional activity information (e.g. schedule, list of specific activities, etc.) may be attached to further inform parent(s) or guardian(s).

ARCHDIOCESE OF CINCINNATI

PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 8-2013)

1. I, the lawful parent or guardian of (**print all children's names**) _____

give permission for my child(ren) to participate in the activity described on the *Activity Information* form and release from all liability and indemnify the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes and schools within the Archdiocese (the "Archdiocese"), and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child(ren) while participating in or traveling to or from the activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child(ren), any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's(ren's) participation is purely voluntary and is a privilege and not a right, and that my Child(ren), and I on behalf of my Child(ren), elect to participate in spite of the risks.

3. I agree to instruct my child(ren) to cooperate with the Archbishop or his agents in charge of the activity.

4. I appoint the Archbishop or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the Child(ren).

(ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child(ren).

5. This power of attorney shall lapse automatically upon completion of the activity and related travel.

6. I agree that the Archbishop or his agents may use my child's(ren's) portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child's family regarding ministry related activities. (Facebook, texting, etc.)

7. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Medical Power of Attorney shall be effective and binding upon me, my Child(ren), and my own and my Child(ren)'s personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian _____ Date ____/____/____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No: (w) _____ (h) _____ (cell) _____

Emergency Contact if parent unavailable:

Name: _____ Phone No: (w) _____ (h) _____ (cell) _____



**Medical Insurance Information to be completed by Parent or Guardian
(Please Print Clearly)**

Medical Insurance Company _____ Policy No. _____
Member's Name _____ Phone No. (h) _____ (w) _____
Member's Birth Date ____/____/____ Member's Social Security # * _____
Family Doctor Name _____ Phone _____
Dentist Name _____ Phone _____

**Medical Information to be completed by Parent or Guardian
(Please Print Clearly)**

Family Name _____ Phone _____

Child's Name _____ Birth Date _____ Grade _____
Child's Soc. Sec. No. * _____
Allergies _____ Medications _____
Health Issues or Chronic Conditions (e.g. epilepsy, diabetes) _____
Learning Disabilities _____

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Learning Disabilities _____

***Social Security number is optional; however, please note that some hospitals WILL NOT TREAT without it.**

If information should be sent to a parent at another address, please provide the following:

Student name _____ Parent/Guardian _____
Relationship _____ Address _____
Phone _____ Email _____