FAITH FORMATION REGISTRATION

St. Francis of Assisi Church, 6245 Wilmington Pike, Centerville, Ohio 45459   937-433-1013 Ext. 1006

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).

____Date________________

Parent/Guardian Signature

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

STUDENT REGISTRATION

September 2018 – May 2019

Student Name ____Grade for 2018/19_____ 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 2018/19____

Student Name ____Grade for 2018/19_____ 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 2018/19____

Student Name ____Grade for 2018/19_____ 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 2018/19____

ACTIVITY INFORMATION

Church Agency: St. Francis of Assisi
Program: Faith Formation Program
Starting Date: September 1, 2018
Ending Date: May 31, 2019
Routine Activities: Faith Formation Classes & Retreats
Usual Location: St. Francis of Assisi Parish
Usual Day and Time: Gr. 6-8 @ Mon 7-8:30 pm,
Transportation: None
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 7:00-8:30pm & Thurs 7:00-8:30pm; First Reconciliation & First Communion Retreats @ Sun. 12:30pm-4:30 pm
Registration Fees: Early Bird (May1-31st) - Student: $65, Home School: $40;
Full Tuition (after May 31st)-Student: $85, Home School: $45
Coordinator of Elementary Faith Formation: Sylvia Carmody **Phone No**. 433-1013, ext 1009 **Email:** scarmody@sfacc.org
Coordinator of Jr. High Faith Formation: Phyllis Wilemaitis **Phone No.** 433-1013, ext 1020 **Email:** pwilemaitis@sfacc.org
Coordinator of Sr. High Faith Formation: Marty McClain **Phone No.** 433-1013, ext 1004 **Email:** mmcclain@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. 1-2018)

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

_____

the "child(ren)"), give permission for my child(ren) to participate in the activity described on the *Activity Information* form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese, and all parishes and schools within the Archdiocese, and their respective 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 respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's(ren's) participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child(ren), and I on behalf of my Child(ren), agree to my Child's(ren's) participation in the Activity 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 to seek medical treatment of my child(ren) in the event of any injury, illness or medical emergency occurs during the activity or related travel. 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. I [ ] agree [ ] do not 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(ren) regarding ministry related activities.

6. 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 Authorization to Seek Medical Treatment shall be effective and binding upon me, my Child(ren), and my own and my Child's(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)_____

⇒ **PLEASE COMPLETE REVERSE** ⇒

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____

Child's Name _______________________________________Birth Date _____________Grade _________

Child's Soc. Sec. No. * _______________________________

Allergies ______________________________________ Medications _______________________________

Health Issues or Chronic Conditions (e.g. epilepsy, diabetes) ______________________________________

Learning Disabilities____

Child's Name _______________________________________Birth Date _____________Grade _________

Child's Soc. Sec. No. * _______________________________

Allergies ______________________________________ Medications _______________________________

Health Issues or Chronic Conditions (e.g. epilepsy, diabetes) ______________________________________

Learning Disabilities____

Child's Name _______________________________________Birth Date _____________Grade _________

Child's Soc. Sec. No. * _______________________________

Allergies ______________________________________ Medications _______________________________

Health Issues or Chronic Conditions (e.g. epilepsy, diabetes) ______________________________________

Learning Disabilities____

***Social Security number is optional; however, please note that some hospitals WILL NOT TREAT without it.**
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If information should be sent to a parent at another address, please provide the following:

Student name ___________________________ Parent/Guardian ________________________________

Relationship ________________________ Address ____

Phone ________________________________ Email ____