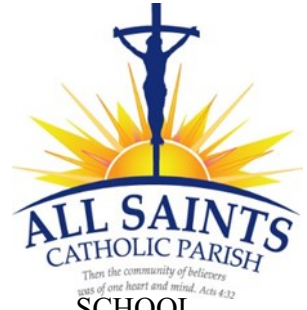


# All Saints Parish Youth Ministry

## Student Registration Form



This Registration Form covers all weekly Youth Ministry gatherings and any event taking place at any of our campuses.  
(St. Anne, St. Bernard, St. Mary, St. John or Holy Cross Cemetery)

(Please Print)

STUDENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ GRD \_\_\_\_\_ SCHOOL \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ GRD \_\_\_\_\_ SCHOOL \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ GRD \_\_\_\_\_ SCHOOL \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ GRD \_\_\_\_\_ SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_

Street

City

Zip

Student's e-mail \_\_\_\_\_ Parent's email \_\_\_\_\_

We sometimes use email for our correspondence. When filling in the email address requests above, **please only give addresses that are viewed regularly.**

**Are you signed up for Flocknote?** \_\_\_ Yes \_\_\_ No **Do you want me to sign you up?** \_\_\_ Yes \_\_\_ No, I will sign up myself. \_\_\_

Home Phone # \_\_\_\_\_ Student's Cell phone# \_\_\_\_\_

Parents Name(s) \_\_\_\_\_

Parents Cell #(s) \_\_\_\_\_

(Name and Number)

(Name and Number)

Any Special dietary needs? \_\_\_\_\_

Food Allergies? \_\_\_\_\_

Emergency Contact Person and phone number (additional-other than names and numbers listed above)

Name \_\_\_\_\_ Phone \_\_\_\_\_ cell \_\_\_\_\_

Additional Information we should know about: (Medical info should be listed on the Medical Release Form)

**Media/Promotions Release:** I give permission for All Saints Parish and the Diocese of Gaylord to use pictures taken during Youth Ministry or at Youth Ministry events for promotional purposes in the bulletin, website and on Facebook. No names will be used with these pictures. It is my understanding that my signature releases the Diocese of Gaylord and All Saints Parish from any financial or legal responsibility for the use of this media relations/promotional materials.

Parent or Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

No student is allowed without paperwork. If you have any questions, call Jackie Benson 989-590-8649.

# All Saints Parish

## Medical Treatment Release Form



To whom it may concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed physician in an emergency which, in the opinion of the attending physician, is deemed necessary and appropriate. This authority is granted only after reasonable effort has been made to reach me.

**List all students covered by this release:**

Name of minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Name of minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Name of minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

**Reason for which intended:** Authorizes medical treatment under emergency circumstances in the absence of parent/guardian from 9-1-19 through and including 8-31-20

Address of minor: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

List Allergies, medication, contacts, or other pertinent comments:

**Include child's name if multiple children are covered by this release.**

\_\_\_\_\_  
\_\_\_\_\_

**Health Insurance Data:**

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

**Does this policy apply to all children? \_\_\_yes \_\_\_no (If no, please provide info on reverse side)**

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice

of Privacy Rights that may be presented by the physician or health care facility.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_