Catholic Community of Manistee

Faith Formation Program Registration
Preschool - Grade 5
Book fee: $25.00 per child or $50.00 per family

CYC Middle School Registration

Amount Paid
$__________
Date:___________
______cash
_________check

OLDEST STUDENT INFORMATION   Additional children on back or pg 2.

PLEASE PRINT CLEARLY

First Name: ______________________________ Birthdate: ______________

Last Name: ______________________________ M/F: ________

Address: ____

Phone: ______________ Cell: ______________ School: ____________ Grade: ______

EMERGENCY CONTACT PERSON *(other than parent)*

Name: ______________________________ Phone:______________

SACRAMENTS RECEIVED   ***For Changes and New Registrations only**

Baptism (Y/N) ________

Where? ______________________________

Year? ____________

Reconciliation? (Y/N) ______

Confirmation? (Y/N) _______

First Eucharist? (Y/N) ______

FAMILY INFORMATION

PARENT SIGNATURE REQUIRED ON BACK OF FORM

Child lives with (please check): ☐ Parents ☐ Mother/Step-father ☐ Father/Step-mother

Father

First name: ______________________

Last name: ______________________

Religion: ______________________

Work phone:______________________

Address (if different)________________

____

Mother

First name: ______________________

Last name: ______________________

Maiden name: ______________________

Religion: ______________________

Work phone: ______________________

Step-mother

First name: ______________________

Last name: ______________________

Work phone: ______________________

Step-father

First name: ______________________

Last name: ______________________

Work phone: ______________________

Email (s): ____

- **PLEASE NOTE IF THERE ARE ANY INFORMATION CHANGES FROM LAST YEAR**

_____ **No Changes** _____ **Changes** _____ **New Registration**

ADDITIONAL CHILD INFORMATION

For those registering more than one child

STUDENT INFORMATION

(PLEASE PRINT)

First name: ____ **M/F:** __________

Last name: ____ **Birthdate:** __________________

School: ____ **Grade:** ________

SACRAMENTS RECEIVED ***For Changes and New Registrations only**

Baptism (Y/N) _______ **Reconciliation? (Y/N)** _____

Where? ____ **Confirmation? (Y/N)** ______

Year? ______________ **First Eucharist? (Y/N)** _____

STUDENT INFORMATION

(PLEASE PRINT)

First name: ____ **M/F:** __________

Last name: ____ **Birthdate:** __________________

School: ____ **Grade:** ________

SACRAMENTS RECEIVED ***For Changes and New Registrations only**

Baptism (Y/N) _______ **Reconciliation? (Y/N)** _____

Where? ____ **Confirmation? (Y/N)** ______

Year? ______________ **First Eucharist? (Y/N)** _____

Registered members of which church: ___ Guardian Angels ___ St. Joseph ___ St. Mary

AUTHORIZATION FORM

As parent/guardian of ____, I understand that promotional pictures audio and/or video recording (individual and group) may be taken during events and activities offered through the Catholic Community of Manistee Faith Formation Program or the Diocese of Gaylord. I hereby give permission, without remuneration, for my child's name, picture, age, parish/school, city, verbal or written remarks and parent(s) names, to be used for news, educational and promotional materials (including, but not limited to, print, audio, video, broadcast, displays, web pages, calendars, PowerPoint, bulletins, etc.) for the Catholic Community of Manistee Faith Formation Program, as well as the Diocese of Gaylord. I also hereby agree to release and hold harmless the Catholic Community of Manistee Faith Formation Program, the Diocese of Gaylord, as well as any of their employees or representatives, including volunteers, from any and all claims resulting from the use of the above information regarding my child.

Signature of Parent/Guardian ____ Date: ____________________

Printed Name of Parent/Guardian ____

Parents may cancel this authorization at any time by providing written notice to:
Catholic Community of Manistee 254 Sixth Street, Manistee, MI 49660

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. 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:____________________ **State:** _________ **Zip:** __________ **Phone:**____________

Emergency Phone: ________________________________ **Date of Birth:** _______________

Family Physician: ____

Address:____

City: ______________________ **State:** _________ **Zip:** _________ **Phone:**____________

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

Allergies:____

Medications:____

Comments/Other:____

Health Insurance Data: ____

Company:_________________________________ **Policy:** ________________________

Group: ___________________________________ **Contract:** ______________________

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 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:** ____________________________