

**CHURCH OF THE ANNUNCIATION/ST. JOHN CHRYSOSTOM
FAITH FORMATION PROGRAM
REGISTRATION FORM/PARENT CONTRACT**

Student's Full Name

Last	First	Middle	Date of Birth
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School Attending _____ School Grade Level _____

Father's Full Name _____

(Guardian)

Mother's Full Name _____

(Guardian)

Home Phone Number _____ Work Phone Number _____

Mobile Phone Number _____

Address _____

City _____ State _____ Zip Code _____

E-Mail Address _____

Emergency Contact _____ Phone# _____

Primary Language spoken in the home: English _____ Spanish _____ Other _____

Please check below which sacraments your child has ALREADY received:

_____ Baptism

_____ Reconciliation

_____ Eucharist

Grades of Faith Formation **COMPLETED:** ___K___ 1 ___2___ 3 ___4___ 5 ___6___ 7 ___8___

PLEASE SUPPLY A COPY OF YOUR CHILD'S BAPTISM RECORD EVEN IF THEY WERE BAPTIZED AT ANNUNCIATION OR ST. JOHN CHRYSOSTOM

I, the parent/guardian, acknowledge that I am the **PRIMARY EDUCATOR** of my child and agree to fulfill my obligation to this program by:

A. Providing transportation to and from Faith Formation each week.

B. Actively participating in all programs/events pertaining to my child's Faith Formation or Sacramental process.

C. Being aware of my child's lessons/prayers and reviewing them with him/her each week.

D. ENSURING ATTENDANCE AT REGULAR SUNDAY MASS

Parent/Guardian Signature

Date

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MEDICAL CONSENT FORM

To whom it may concern:

The undersigned does hereby request permission for our child to attend and participate in activities sponsored by Church of the Annunciation/St. John Chrysostom.

We authorize any designated adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care to be rendered to the minor under general or special supervision and on the advice of any physician or dentist licensed under the provision of the Medical Practice Act on the medical staff of a Licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agrees to pay all costs and expense incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for your child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Medical consent forms will be used only as needed. Every effort will be made to first notify the parent, guardian or emergency contact prior to the use of the medical consent form.

Hospital Insurance: Yes _____ No _____ Insurance Co. _____

Policy Number _____ Emergency Phone Number _____

_____	_____	_____	_____
MOTHER	DATE	FATHER	DATE
_____		_____	
LEGAL GUARDIAN		DATE	

PLEASE NOTE ANY ALLERGIES OR SPECIAL NEEDS YOUR CHILD MAY HAVE ON THE LINES BELOW:
