

REGISTRATION FORM – QUEST HIGH SCHOOL YOUTH GROUP
for the 2011-12 School Year
ST. CHRISTOPHER’S CATHOLIC CHURCH – MARYSVILLE, MI

FAMILY NAME (Parents’ First & Last Names) _____

HOME PHONE _____

HOME ADDRESS _____

PARENTS’ MOBILE PHONE _____

PARENTS’ EMAIL ADDRESSES _____

PARENTS’ FACEBOOK NAME _____

Attended Protecting God’s Children Workshop? YES NO YES NO

(LIST EACH TEEN SEPARATELY)

TEEN NAME (First & Last Names) _____

TEEN’S MOBILE PHONE _____ Birthday _____

TEEN’S FACEBOOK NAME _____

Attended Called to Serve Workshop? YES NO

TEEN NAME (First & Last Names) _____

TEEN’S MOBILE PHONE _____ Birthday _____

TEEN’S FACEBOOK NAME _____

Attended Called to Serve Workshop? YES NO

TEEN NAME (First & Last Names) _____

TEEN’S MOBILE PHONE _____ Birthday _____

TEEN’S FACEBOOK NAME _____

Attended Called to Serve Workshop? YES NO

EMERGENCY CONTACT (In the event we cannot reach a parent in an emergency situation)

EMERGENCY NAME _____

EMERGENCY HOME NUMBER _____

EMERGENCY MOBILE NUMBER _____

Fill out BOTH SIDES please

Media Consent

St. Christopher Youth Ministry programs engage in various opportunities to use pictures of families, parishioners and other members of the community in the parish bulletin, in pictures around the church & school, and potentially in local newspapers like the Michigan Catholic. I give permission for my teen(s) (listed on reverse side) to be photographed or videotaped for educational and community relations not-for-profit use such as newsletter articles, St. Christopher parish bulletin, community newspaper articles, website, etc.

Parent Signature: _____ Date: _____

Please list any exceptions here _____

Medical Treatment Authorization

As parent/guardian (of teens listed on reverse side), I do hereby authorize the treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authorization is granted only after a reasonable effort has been made to reach me.

Family Physician Name: _____ Phone: _____

List allergies, medications, or other pertinent comments:

Health Insurance Information

Company: _____ Policy: _____

Group: _____ Name of Insured: _____

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

Parent Signature: _____ Date: _____

- I will contact St. Christopher if any of this information changes before the end of the 2011-12 school year. Initials _____

Fill out BOTH SIDES please