Immaculate Conception Church

Faith Formation Registration Form

Student Name: _____
Last Middle First

Sex: M / F Birthdate: ____/____/_____ Grade: _____ School: _____

Sacraments Previously Received: Baptism / Reconciliation / Confirmation / First Eucharist

Father/Guardian: _____
Last First

Address: _____

Phone: _____(Cell) _____(Home)

Email: _____ Religion: _____

Mother/Guardian: _____
Last First

Address: _____

Phone: _____(Cell) _____(Home)

Email: _____ Religion: _____

A registration fee of **$25.00** is payable by cash or check mailed to the Parish Office at:
Immaculate Conception Church
308 N. Cedar Street
Traverse City, MI 49684
(please make checks payable to Immaculate Conception Church) (Write **Faith Formation** on memo line)

Payment may also be made online through the Parish Website at:
www.immaculatetc.org/youth

If you are unable to pay the full fee amount, please pay what you are able to afford.

Immaculate Conception Catholic Church 308 N Cedar Street, Traverse City, MI 49684

MEDICAL TREATMENT RELEASE

To Whom it May Concern:

As a parent/guardian, I do hereby authorize the treatment of my child(ren) by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, causing 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(s)_____

Relationship to you_____

Reason for which release is intended—Immaculate Conception Church Faith Formation Program

Address if Minor_____City_____State_____ Zip_____

Date of Birth_____ Emergency Contact Phone #_____

Family Physician_____ Phone #_____

Address_____City_____State_____ Zip_____

List Child(ren)'s Allergies, Medications, etc.

_____

_____

_____

Additional comments_____

Health Insurance Data:

Company_____ Policy #_____

Group #_____ Contract#_____

I further authorize the person who presents my child(ren) to sign the Acknowledgement 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.

Signed_____ Date_____

(Parent or Guardian)

MEDIA CONSENT

Immaculate Conception Catholic Church and the Diocese of Gaylord engage in various communications regarding programs and activities of the parish and diocese through correspondence and publicity with families, parishioners, as well as media and members of the wider community. This may involve—but is not limited to—photos, video, audio, written materials, bulletin boards, newspapers, radio, television, power point and internet. If you are willing to provide authorization for your child(ren)'s name, image, quotations, age, parish and parents' names to be utilized for such publicity, please complete the form below.

If you are NOT willing to authorize, please check here* ☐ *and sign and date below.

As parent/guardian of _____, I understand that promotional pictures, audio and/or video recording may be taken during events and activities offered through Immaculate Conception Catholic Church and the Diocese of Gaylord during the 2024– 2025 program year. I hereby give permission, without remuneration, for my child(ren)'s name, image, quotations, age, parish, city and parents' names to be used for news, educational and promotional materials for the named parish and diocese. I also hereby agree to release and hold harmless Immaculate Conception church and 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(ren).

_____ _____

Signature of Parent/Guardian Printed name of Parent/Guardian

Date_____ Authorization good for one year from date. Parents may cancel authorization via written notification at any time.