

ST. ELIZABETH YOUTH MINISTRY

917 Montrose Road ☩ Rockville, MD 20852-4203 ☩ 301-881-1380

2023-2024 Registration Form

FAMILY INFORMATION:

Child[ren]'s Last Name: _____ Home Phone: (____) _____ - _____
Children Attending: First Name: _____ Grade: _____ M____ F____
First Name: _____ Grade: _____ M____ F____
Address: Street: _____
City, State & Zip Code: _____
Child[ren] reside[s] with (check one): both parents _____ mother _____ father _____ other _____

PARENT INFORMATION:

Father's Name: _____ Father's Country of Birth: _____
Occupation: _____ Father's Religion: _____
Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
E-Mail (Required): _____ (____ Add to monthly email list.)
Marital Status: (check one) Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Mother's Name: _____ Mother's Country of Birth: _____
Occupation: _____ Mother's Religion: _____
Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
E-Mail (Required): _____ (____ Add to monthly email list.)
Marital Status: (check one) Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

AUTHORIZATION TO PUBLISH PICTURES & ARTWORK

I hereby grant permission to St. Elizabeth Catholic Church to publish pictures of me and/or my child(ren) and any artwork created during youth group meetings on the church's website or in the church's promotional materials, newsletters, or bulletins. No names will be published without permission. I understand that if I give notice to the webmaster that I object to any particular picture of me and/or my child(ren), it will be removed as soon as possible. I understand that my child(ren) and I will not be paid any royalties or other compensation for the publication of any pictures. I further state that I have the right to grant or refuse this permission as I am the child's parent or legal guardian.

MEDICAL TREATMENT and INSURANCE INFORMATION

I hereby authorize any reasonable and necessary medical treatment, administration of anesthesia, and surgical treatment for my minor child(ren) in the event of my absence, or when the hospital or physicians *are unable to contact me*. This authorization extends to any hospital, physician, and nursing personnel on staff where treatment is rendered. I release from liability and waive all claims (with the exception of liability and claims resulting from gross negligence or willful misconduct) against St. Elizabeth Church, church staff, church volunteers, the hospital, physicians, and nursing personnel for performing reasonable and necessary medical procedures in accordance with the authority of this consent for medical treatment.

Insurance Company: _____ Identification Number: _____
Policy Number: _____ Group ID Number: _____

Child(ren)'s Full Names: _____

Child(ren)'s Full Names: _____

Parent Signature: _____

Please complete a half-sheet for each teenager.

STUDENT INFORMATION:

Name: _____ Date of Birth: MM DD YY
Last First Middle Nickname

School Attending: _____ Grade: _____

Languages spoken, written or read at home: _____

Does your child receive testing accommodations in school? _____ Yes _____ No

We ask you to share any learning disability, health challenge (include **ALLERGIES** and **MEDICATIONS**), language problem or home situation which may affect your teen's ability to learn or to participate fully in the Youth Ministry program.

SACRAMENTAL INFORMATION: *(Indicate the sacraments your teen has received within the Roman Catholic Church.)*

Baptism Date: _____ Church: _____

Church Address: _____
Number & Street City, State & Zip Code

Made First Reconciliation? _____ No _____ Yes Year & Parish: _____

Received First Communion? _____ No _____ Yes Year & Parish: _____

Been Confirmed? _____ No _____ Yes Year & Parish: _____

Complete a half-sheet for each child and return to the Parish Office with the previous page. DO NOT DETACH!

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