

# 2015-16 Youth Registration Packet

Please fill out one packet per youth you wish to register (make additional copies if necessary):

Name \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Male Female  
Gender (circle one):

School \_\_\_\_\_ Teen's Cell Phone (if available) \_\_\_\_\_

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**Teen's Email** (By providing your teen's email and/or cell phone, you consent to the teen receiving communications from the parish & its volunteers regarding youth ministry activities through these mediums)

- \_\_\_ I consent to my teen receiving **Facebook** communications regarding youth ministry activities.
- \_\_\_ I consent to my teen receiving **Text and/or Phone calls** regarding youth ministry activities.
- \_\_\_ I consent to my teen receiving **E-mails** regarding youth ministry activities.
- \_\_\_ I consent to my teen being **Photographed** during youth ministry activities for the advertising purposes.  
(ie. parish website, bulletin, Facebook page, & flyers)

**Circle all that apply for this teen:**

Middle school      High school      Confirmation      Needs to receive: Baptism & 1<sup>st</sup> Communion

**Specific Medical Information:** Please answer "N/A" or describe, indicating if you use the reverse sheet for explanations.

- Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_
- Immunizations: Date of last tetanus/diphtheria immunization (if applicable): \_\_\_\_\_
- Medically prescribed diet? \_\_\_\_\_
- Subject to homesickness, emotional reactions to new situations, sleepwalking, bedwetting, etc. \_\_\_\_\_
- Has the child recently been exposed to any contagious disease or conditions, (ex: mumps, measles) \_\_\_\_\_
- Does the child have any physical limitations, or special conditions we should be aware of: \_\_\_\_\_

I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate. If not initialed, medication will only be administered to my child unless the situation is life-threatening and emergency treatment is required. \_\_\_\_\_ (Initial)

**NOTE: a parent and/or guardian will be notified prior to the child receiving any non-prescription medication.**

## Parent/Guardian Contact Information

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone (in case of emergency) \_\_\_\_\_

Father/Guardian's Full Name \_\_\_\_\_ Mother/Guardian's Full Name \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

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Parent's Email (By providing your email, you consent to receiving emails regarding youth ministry activities.)

Have you completed a background check?      Yes      No  
Have you completed/been updated on the Child Protection Class?      Yes      No      Continued →

