

ST. MARY YOUTH MINISTRY

2018-2019 Middle School Registration

Teen and parent information:

Name of teen: _____ Grade: ____ School: _____ Home phone: _____

Cell: _____ E-mail (*write neatly*) _____ After school activities: _____

Mother's name: _____ Home #: _____ Cell: _____ Work: _____

Father's name: _____ Home #: _____ Cell: _____ Work: _____

What gifts, talents, or cool tricks can you do?

Parent do you give permission for the Director of Youth Ministry and the staff to contact your teen via phone text, e-mail & other

social media? Yes No

Parent check if you wish to receive a monthly e-mail with upcoming Youth Ministry information:

Yes No Preferred e-mail: _____

Parental Permission & Liability Release: As the parent/guardian of _____, I hereby give my permission for my child to attend Middle School Youth Group at St. Mary Catholic Church in Fredericksburg, VA on Friday nights. I agree to indemnify and hereby release The Most Reverend Michael Burbidge Bishop of the Catholic Diocese of Arlington and his successors in office, as well as the Catholic Diocese of Arlington and all Diocesan clergy, employees, volunteers, and participating parishes and schools from any and all liability, claims, demands for personal injury, sickness and death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned of the participant resulting from said participant's involvement in the above mentioned event (including transportation to and from the event). Furthermore, I on behalf of the participant hereby assume all risk of personal injury, sickness, death, damage, and expenses resulting from said participant's involvement in the above described event.

Informed Consent to Medical Treatment: I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participant to return home due to medical, disciplinary, or other reasons, I do hereby assume responsibility for the participant's transportation home and any costs related thereto.

Photo: Also, I authorize the Diocese of Arlington to use my child's picture or video recording for educational and/or marketing purposes. Parents/guardians who do not wish their child to be photographed or filmed should notify the Office of Youth Ministry in writing.

Date of Birth

If a Vegetarian please specify here

Allergies or medical conditions/concerns (Continue on back of form if needed)

Name of Parent/Guardian

Parent(s) e-mail address

Address

City

State & Zip Code

Person to notify if parent/guardian is unavailable

Phone: Home

Work

Cell

Insurance Carrier & Policy Number

Family Physician Phone

Signature of Parent/Guardian

Date