

Prince of Peace Parish Catechesis of the Good Shepherd Registration 2022-2023

Last Name _____ **Address / Zip Code** _____

Father's Name _____ **Mother's Name** _____
Legal or Custodial Parent Legal or Custodial Parent

Religion: _____

Email Address: _____

Cell Phone: _____

Name and Information	Birth Date	Age	School	Grade	Baptized (yes/no)	Eucharist (yes/no)	Reconciliation (yes/no)	CGS Level / Day
Child: _____								
Any medical information or special needs we need to know?								
Child: _____								
Any medical information or special needs we need to know?								
Child: _____								
Any medical information or special needs we need to know?								

If I cannot be reached during an emergency, call _____ relationship _____ phone _____

My child(ren) may also be released to _____ relationship _____ for carpool purposes only

My child/ren will be enrolled in Level 1 / 3-6 years old / Atrium Limit - 10 Children
 _____ Level 1 - Monday 10am-Noon _____ Level 1 - Monday 4:30-6:00 pm _____ Level 1 - Wednesday 6:00-7:30pm

My child/ren will be enrolled in Level 2 / 6-9 years old / Atrium Limit - 15 Children
 _____ Level 2 - Monday 10am-Noon _____ Level 2 - Monday 4:30-6:00 pm _____ Level 2 - Wednesday 6:00-7:30pm

My child/ren will be enrolled in Level 3 / 9-12 years old / Atrium Limit - 15 Children
 _____ Level 3 - Monday 4:30-6:00 pm _____ Level 3 - Wednesday 6:00-7:30pm

Registration Fee: \$25/child or \$75.00/family **Please make checks payable to: Prince of Peace Parish** *** Scholarships are Available ***

Parent Signature _____ **Date** _____ **Volunteer** _____ **Check No/ Cash** _____ **Waiting List** _____



DIOCESE OF GRAND RAPIDS

MEDIA RELATIONS/PROMOTIONS RELEASE FORM

NAME: _____

ADDRESS: _____
Street City State Zip

PHONE: _____

RELEASE

IF PERSON BEING USED IN THE MATERIAL IS UNDER 18 YEARS OF AGE, PARENT OR LEGAL GUARDIAN MUST SIGN THIS FORM.

I/we give my/our permission to the Roman Catholic Diocese of Grand Rapids, Michigan, (the Diocese) and all entities, representatives, employees, and agents operating under its authority to use, without prior notice, my name or my minor child's name, city and state, and/or audio, video(s), photo(s), and/or any other likeness and to use statements made by or attributed to me or my child relating to the Diocese, without compensation, for web, social media, publicity or similar promotions for the Diocese. I waive my right to inspect or approve such publications, including any written copy that may be created in connection therewith. ***I/we agree that my/our signature(s) below releases any and all claims against the Roman Catholic Diocese of Grand Rapids, or its associated entities related to or arising out of the Diocese's use of the stated items as media relations/promotional material(s).***

Yes, I grant permission for release

No, I do not grant permission for release

Signature of Individual (if 18 or older): _____

Date: _____

Name of Parent/Legal Guardian (print): _____
(if individual is under 18 years old)

Signature of Parent/Legal Guardian: _____

Date: _____

If individual referenced above is under 18, please indicate your relationship to that person: _____

*Once completed, please return this form to your parish/school administration office

MEDICAL TREATMENT RELEASE FORM
Prince of Peace Parish, 1110 Dykstra Rd, N Muskegon, MI 49445

ONE PER CHILD

To Whom It May Concern:

As a parent/guardian, 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 authority is granted only after a reasonable effort has been made to reach me.

Name of child: _____

Relationship to you: _____

Reason for which release is intended: **Children's Ministry Formation, Sacrament Sessions and Retreats, Vacation Bible School, and Special Events**

Address of Child: _____

Emergency Phone(s): _____

Family Physician: _____

Phone: _____

Physician's Address: _____

List allergies, medication, contact, or other pertinent comments:

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

Company Address: _____

I further authorize the person who presents the minor to sign the Acknowledgement 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.

Date: _____

Signed: _____

(Parent or Guardian)

