Due by August 10, 2018

St. Charles Borromeo Faith Formation Program - CCD

Registration Form 2018-2019 and Fees Due August 10 **Faith Formation Office**: (937) 434-9272, or bgregg@stcharles-kettering.org

Student Information - Please Print

Family Last Name: _____ Best Contact Phone #: _____

Address: _____ City: _____ Zip: _____

Best Contact Email: _____

Registered Member of St. Charles? ____ Yes ____ No ____ Other Parish: _____

Previously in our Faith Formation program? ____ Yes ____ No ____ Other Parish: _____

If other parish, my children attended from (year) _____ until _____

Student(s) Name	M/F	Birth Date	2018/19 Grade	School	✓ Sacraments Received			
					Bapt	Recon	Euch	Conf

Parent Information

Mother's Name (with Maiden Name): _____ Religion: _____

Address (if different from student): _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone :_____ Work Phone: _____

Father's Name: _____ Religion: _____

Address (if different from student): _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone :_____ Work Phone: _____

ARCHDIOCESE PERMISSION FORM: Please complete the attached (2-sided) permission form. Be sure to report any allergies, medical/special needs we should be aware of concerning your children. In case of emergency, parents will be contacted at the phone numbers above, then the emergency contact on the permission form.

2018-2019 REGISTRATION FEES: $60.00 per student or $180.00 per family maximum

Number of students Grades 1-8* _____ X $60.00 or $180.00 maximum = _____

*If registering a 6th grader, add a $10.00 Youth Bible fee per student + _____

TOTAL DUE BY AUGUST 10th $ _____

If you are requesting to pay in installments or requesting financial assistance, please select one of the following:

☐ I would like to pay in installments of $_____ per payment. The first payment is due by **August 10, 2018** and will be paid in full by **December 21, 2018**.

☐ I am requesting financial assistance. Please contact me at _____.

Checks made payable to St. Charles Parish, and delivered to the Office of Faith Formation, 4600 Ackerman Blvd., Kettering, Ohio 45429. Please direct any inquiries to (937) 434-9272, or bgregg@stcharles-kettering.org.

Parent/Guardian Signature _____ **Date:** _____

Office Use Only:

Payment #1 Date: _____	Check #: _____	Amount: _____
Payment #2 Date: _____	Check #: _____	Amount: _____
Payment #3 Date: _____	Check #: _____	Amount: _____
Payment #4 Date: _____	Check #: _____	Amount: _____

ACTIVITY INFORMATION

Church Agency: St. Charles Borromeo Parish
Usual Location: St. Charles School
Routine CCD Activities
Registration Fee - See Cover Letter

Program or Group CCD Gr. 1-5
Usual day and time: Tuesdays 4:00 – 5:15 p.m.
Dates: Sept. 11, 2018 - May 14, 2019
Group Leader: Erin Fanning
Telephone: (937) 434-9272

Program or Group CCD Gr. 6-8
Usual day and time: Sundays 6:30 – 8:00 p.m.
Dates: Aug. 19, 2018 - Apr. 28, 2019
Group Leaders: Erin Fanning and Heather Dunn
Telephone: (937) 434-9272

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 11-2016)

1. I, the parent or lawful guardian of (children's names) 1. _____,

2. _____, 3. _____ give permission for my child(ren) to participate in the activity described on the *Activity Information* form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the Activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks.

3. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

4. I appoint the Archbishop or his agents who are acting as leaders of the Activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the Child.

(ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

5. This power of attorney shall lapse automatically upon completion of the activity and related travel.

6. I agree that the Archbishop or his agents may use a photograph, video or other likeness of my child for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities.

7. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Medical Power of Attorney shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian _____ **Date**_____/_____/_____

Home Address _____ City _____ Zip_____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (W) _____ (H) _____ (C) _____

Emergency Contact _____

Phone No. (W) _____ (H) _____ (C) _____

Parent or Guardian Must Complete Medical Information on the Back

ARCHDIOCESE OF CINCINNATI (Continued)
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 11-2016)
Medical Information — Completed by Parent or Guardian — Please Print

1. Child's Name _____ Birth Date _____/_____/___

Child's Soc. Sec. No.* _____

Allergies / _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes)_____

_____

2. Child's Name _____ Birth Date _____/_____/____

Child's Soc. Sec. No.* _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

_____

3. Child's Name _____ Birth Date _____/_____/____

Child's Soc. Sec. No.* _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

_____

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Medical Insurance Co. _____ Policy # _____

Member's Name _____ Phone (W) _____ (H) _____

Member's Birth Date ____/_____/____ Member's Social Security #* _____

Family Doctor _____ Phone _____

Signature of Parent or Guardian _____ **Date** _____/_____/_____

* Social Security number is optional; however, please note that some hospitals WILL NOT treat without it.