

SAINT ANN CATHOLIC CHURCH310 North Olive Avenue
West Palm Beach, FL 33401**Director of Religious Education****Mrs. Veronica Matias**

ReligiousEd@stannchurch.net

561-832-3757 ext. 304

REGISTRATION FOR RELIGIOUS EDUCATION 2017-2018**Please print clearly and fill out registration completely-ALL information is needed****DATE:**

Family Last Name _____ Registered at St. Ann's? _____ Env# _____

Family Street Address _____

City _____ State _____ Zip Code _____

Child resides with: **(Please circle)** Both Parents Mother Father Other _____

Mother's Last Name _____ First _____ Middle _____

Mother's **Maiden** Name _____ Occupation _____ Religion _____

Mother's Home Phone (____) _____ - _____ Cell # (____) _____ - _____

Mother's E-mail Address _____

Father's Last Name _____ First _____ Middle _____

Father's Home Phone (____) _____ - _____ Cell # (____) _____ - _____

Father's E-mail Address _____ Occupation _____ Religion _____

Children enrolled in program:	Child 1	Child 2	Child 3	Child 4
First Name:				
Last Name:				
Birth Date & Gender:				
School & Grade:				
Baptism Place & Date:				
1st Reconciliation P & D:				
1st Communion P & D:				
Confirmation P & D:				

A copy of the Baptismal, First Communion, and Confirmation Certificates are REQUIRED if they occurred at a Church other than St. Ann's. Please INCLUDE with REGISTRATION before classes begin.

PROGRAM Material FEES: \$40.00 per Child or \$100.00 per Family. Field Trips & Retreats will be extra

For Office Use

Baptism, First Communion, & Confirmation certificates received: _____ / _____ / _____

Notes/Remarks: _____

File Document Until: _____

Photograph and/or Videotape Consent & Release

I hereby grant to St. Ann Catholic Church the right to photograph and/or videotape me and further to use my name, face, likeness, voice, and appearance in connection with exhibitions, publicity, advertising, and promotional materials without any reservation, limitation, or consideration. This waiver specifically releases any common law causes of action or claims under Fla. Stat. 540.08 and expressly constitutes written consent for publication of my name, face, likeness, voice and appearance.

Signature of Participants: _____/_____/_____/_____ Date: _____

I, _____, (parent/guardian) certify that I am the parent or legal guardian of the above-signed participants and that I have read the foregoing release and examined the information in the description. I hereby join in each and every part of this Photograph and/or Videotape Consent and Release (including such part as may subject me to personal financial responsibility) and hereby relinquish any claims that I may have against St. Ann Catholic Church as set forth above, both in my own behalf and in my capacity as legal representative (as applicable) of the participants, including without limitations any claims arising as a result of the participants leaving the supervision of St. Ann Catholic Church. I agree that if any portion of this document is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

Signature of Parent/Guardian: _____ Date: _____

Each year the Parish of St. Ann is required by the Diocesan Office of Protection of Children to hold a session on Protecting God’s children. These videos deal with different topics of sexual nature; they are age appropriate. The date of the sessions will be announced in the schedule and reminded weeks ahead. Parents are encouraged to attend the sessions with their children. If you DO NOT want your child to participate please check the box.

I do not want my children to attend

Parent/Guardian: _____ Date: _____

Catechetical Program Medical Release Form

I, _____, (parent/guardian) give St. Ann Catholic Church Religious Education and its designated representative permission to transport and sign all forms related to the necessary medical treatment for _____ (children).

I also permit any and all required medical treatment to be administered by qualified medical personnel, including calling 911. I understand the parish of St. Ann is not responsible for expenses that may arise from such treatment.

Emergency Contact- Name: _____ Relationship _____

Address: _____

Phone Number: Home _____ Office _____ Cell _____

Preferred Hospital: _____ Doctor: _____ Phone: _____

List all medications your children are taking (indicate for which Child and condition): _____

List all known allergies and medications your children are allergic to: _____

Please also indicate any health conditions or special care information necessary to ensure the appropriate medical attention is provided. _____

Parent/Guardian: _____ Date: _____