Guardian Angels Catholic Church Faith Formation Program Registration:2024-2025

581 East 14 Mile Road, Clawson, MI 48017 (248) 588-1222 Fax (248) 589-7356

Father_____ **Professed Religion** _____
Last name First Name (Catholics state Rite: Roman, Maronite, Chaldean, etc.)

Home Phone_____ **Work** _____ **Cell** _____ **Email**_____

Address_____ **City**_____ **Zip**_____

Mother_____ **Professed Religion**_____
Last name First Name (Catholics state Rite: Roman, Maronite, Chaldean, etc.)

Home Phone_____ **Work** _____ **Cell** _____ **Email**_____

Address_____ **City**_____ **Zip**_____
(If different from above)

Marital Status of Parents/Guardians: (Circle One) **Married Separated Divorced Widowed Single**

Remarried Name_____ **and/or Step-parent Name**_____

Parent(s)/Guardian(s) to whom mail is addressed_____

Cost is $135 for the first child and $120 each additional child for a registered parish member. (Out of parish cost is $180 per child.) Minimum of $25 per child due at registration. Please return registration by September 16; classes start September 30.

Students First Name (and Last if different from parents/guardians)	M/F	Grade	Baptized Y/N Parish	First Communion Y/N Parish	Confirmation Y/N Parish

Sacrament Preparation Fees: Grade 2—$10 Grade 6—$15

Payment options: A=Payment in full at registration B=1/2 at registration, 1/2 in March C=6 monthly payments (Oct-March)

Please circle option and include payment A B C Please make checks payable to Guardian Angels

*****If new to the program, please provide a copy of your child's Baptismal Certificate with registration unless baptized at GA.***

I RECOGNIZE THAT I AM MY CHILD'S PRIMARY TEACHER OF THE FAITH. Having chosen this faith formation program for my child, I will be actively involved in helping my child grow in his/her Catholic faith. Parent signature_____

Emergency Information *(other than parent, in case of child's illness or class cancellation)*

Name: _____

Telephone _____ Relationship_____

Photography Consent Waiver:

I understand that photography and/or video of my child may be taken during any of the Guardian Angels Faith Formation Programs to be used in the publication of parish newsletters, Guardian bulletins, and/or parish website.

MEDICAL TREATMENT RELEASE FORM

As parent/guardian of _____, I do hereby authorize his/her 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.

I further authorize the person who presents the minor to sign the Acknowledgment 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 _____
Signature of Parent or Guardian

_____Phone_____
Name and Address of Child's Physician or Health Clinic

_____ _____
Hospital Preferred for Emergency Treatment Allergies, Medication, Pertinent Comments

_____ _____
Date of Last Tetanus Shot Health Insurance: Company Name; Policy: Group; Contract

Special Needs: