	DGE ®	v	• •	th School St Formation 2		
Catho	olic Middle School Ministry	20523 Huebne	r Road	San Antonio, T	exas 78258	210-497-4145
Sacraments Already Celebrated Please Check all that Apply Baptism First Eucharist Reconciliation	7th Grade: This is	Please check one of t my first year of middle s my second year of middl my third year of middle s	chool faith e school fa	a formation. (\$50) aith formation. (\$5	0)	Student T-Shirt Adult sizes (Check One) Small Medium Large XL 2XL
		PLEASE PRINT	Г CLEAI	RLY		
	First		Student	Last Cell # May we text your o		Nick Name
2014-2015 Grade:	Name of Scho	ol:		5 5		
	Father]	Mother	
Father Home Phone:	_ ()	Moth	er Home F	Phone: ()		
Father Mobile Phone	:_ <u>(</u>)	Moth	er Mobile	Phone: <u>(</u>)_		
			Ci	ty	State	Zip Code
Mother Email:	AL RELEASE FORM y videotapes, photograph ppear. I understand that nd the Archdiocese of Sa Parent Signature	L consent to the use is, slides, audiotapes, o these materials are bei in Antonio. Such pron	by Holy or any oth ng used f notional a	Trinity Catholic or er visual or audic or promotion of t ctivities extend to	Church and the preproduction in the youth minist precruitment, fr	Archdiocese of n which I or my ry of Holy Trinity and-raising, advo-
the cost of text are available ar be denied inst Church.	ormation — The 2 books, supplies and nd arrangements car ruction for financi Check #	materials. Full o n be made for fam al reasons. Please	r Partia ilies wł make o	l scholarships	for Faith Fo cial assistance le to Holy Tr	ormation fees ce. No teen will rinity Catholic

Medical Consent and Permission to Treat

	best of my knowledge, my child,	, is in good health,				
	ssume all responsibility for the health of my child. ency Medical Treatment: In the event of an emergence	2.77				
0	<u>I hereby grant permission to transport my child to a hospital for em</u>	•				
	Yes No	ergency medical treatment				
-	I wish to be advised prior to any further treatment by the hospital or	r doctor. Yes No				
Doront/C-	Guardian'a Nama					
Home Ac	Guardian's Name:					
Home Ph	Address:					
	re unable to reach me, please contact:					
Name:	nship to me or my child:					
Lomo Dh	Phone: () Cell Phone: ()					
Family d	doctor: Phone Number: ())				
r annry u		_)				
Please in	include a photocopy of your Insurance Card (front a	and back).				
-	Insurance Carrier: Policy No:	,				
-	My child is taking medication and I will bring all me	dication & turn them into				
	the Retreat Staff. It will be clearly labeled. All medi	ication(s) and directions				
	for taking this medication, including dosage, frequen	cy and storage are as				
	follows:					
	I hereby grant permission for non-prescription medic	ation (such as couch				
-	drops, cough syrup, Tylenol, etc.) to be given if nece					
_	I understand that aspirin will not be given to <u>my</u> child					
	permission. I hereby grant such permission: Yes					
-	My child is allergic to the following (medications, fo	ods. plants. insects. etc):				
	j	, r ,,,,,,,				
-	My child's immunizations are current and up to date:	Yes No				
-	My child's last tetnus/diphtheria immunization:					
-	My child has the following physical limitations:					
-	My child experiences homesickness, emotional reactions to new situations,					
	sleepwalking, fainting, bed wetting, etcYes	Nof Yes, please				
	explain:	disage or condition such				
-	as mumps, measles, chickenpox, etc. <u>Yes</u> No					
	date and disease or condition:					