



All Saints Catholic Community

St. Ann – St. Edward
St. Stephen and St. Theresa

**Family Faith Formation
Sacramental Preparation
Youth Group
2022-2023 Registration**

Family Information

Last Name _____ Home Parish _____
Street Address _____
City/Zip Code _____

Contact Information Parent 1

First Name _____ Last Name _____
Cell Phone _____ Alt. Phone _____
Email _____

Contact Information Parent 2

First Name _____ Last Name _____
Cell Phone _____ Alt. Phone _____
Email _____

Child 1

First Name _____ Last Name _____
Grade _____ Birth date _____
Sacraments Received: Reconciliation Confirmation First Eucharist

Child 2

First Name _____ Last Name _____
Grade _____ Birth date _____
Sacraments Received: Reconciliation Confirmation First Eucharist

Child 3

First Name _____ *Last Name* _____

Grade _____ *Birth date* _____

Sacraments

Received: Reconciliation Confirmation First Eucharist

Child 4

First Name _____ *Last Name* _____

Grade _____ *Birth date* _____

Sacraments

Received: Reconciliation Confirmation First Eucharist

Child 5

First Name _____ *Last Name* _____

Grade _____ *Birth date* _____

Sacraments

Received: Reconciliation Confirmation First Eucharist

**Additional paperwork is needed for Sacramental Prep students, please see Jen Geiger if you have a child who needs to prepare for sacraments.*

Flocknote Communication Permission

We use a messaging service called Flocknote to contact families about our programs via email & text.

List Parents to be texted/emailed _____

Many students like to also receive these notifications. We may copy your HS/MS child(ren) the texts/emails that you receive?

texts on their cell phone/s # _____

Emails to address/es _____

Parent Signature _____ Date: _____



800 WEST 13TH STREET • CADILLAC, MICHIGAN 49601
PARISH OFFICE (231) 775-2471 • FAX (231) 775-0161

ST. ANN-ST. EDWARD

The parishes of St. Ann, St. Edward, St. Theresa, St. Stephen (All Saints Catholic Community) and the Diocese of Gaylord, engage in various communications regarding programs and activities of the parish, school and diocese through correspondence and publicity with families, parishioners, as well as mass media and members of the wider community. This may involve -- but is not limited to -- photos, video, audio, written materials, bulletin boards, newspapers, radio, television, PowerPoint, Internet, etc. Please provide authorization for your child's name, picture, age, parish/school, verbal or written remarks, and parent's names to be utilized for such publicity by completing the form below.

As parent/guardian of _____,
I understand that promotional pictures, audio and/or video recording (individual and group) may be taken during events and activities offered through the All Saint Catholic Community or the Diocese of Gaylord. I hereby give permission, without remuneration, for my child's name, picture, age, parish/school, city, verbal or written remarks and parent(s) names, to be used for news, educational and promotional materials (including, but not limited to, print, audio, video, broadcast, displays, web pages, calendars, PowerPoint, bulletins, etc.) for the All Saint Catholic Community, as well as the Diocese of Gaylord. I also hereby agree to release and hold harmless the All Saint Catholic Community and the Diocese of Gaylord, as well as any of their employees or representatives, including volunteers, from any and all claims resulting from the use of the above information regarding my child.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Parents may cancel this authorization at any time by providing written notice to, St. Ann Parish , 800 W 13th St, Cadillac, MI 49601

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. The authority is granted only after a reasonable effort has been made to reach me.

Name of Minor/s: _____

Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____ - _____

Date of Birth: _____

Emergency Phone: _____

Family Physician: _____

Physicians Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____ - _____

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

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data: _____

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of 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: _____