



**All Saints Catholic Community**

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

**Family Faith Formation  
Sacramental Preparation  
Youth Group  
2023-2024 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: \_\_\_\_\_