

**ST. IRENAEUS CHURCH  
YOUTH FAITH FORMATION**

FAMILY LAST NAME \_\_\_\_\_  
(Please Print)

ADDRESS \_\_\_\_\_ MOM'S CELL \_\_\_\_\_ DAD'S CELL \_\_\_\_\_  
City & Zip \_\_\_\_\_

PRIMARY EMAIL \_\_\_\_\_ WORK PHONE \_\_\_\_\_ (Dad or Mom)

FATHER/GUARDIAN \_\_\_\_\_ RELIGION \_\_\_\_\_  
LAST FIRST MIDDLE

MOTHER/GUARDIAN \_\_\_\_\_ RELIGION \_\_\_\_\_  
LAST FIRST MIDDLE

ARE YOU A REGISTERED MEMBER OF ST. IRENAEUS PARISH? YES \_\_\_ NO \_\_\_ DO YOU LIVE IN THE PARISH BOUNDARIES? Y \_\_\_ N \_\_\_  
LANGUAGE SPOKEN IN THE HOME \_\_\_\_\_

List any children who have any Special Needs and specify the need: \_\_\_\_\_

I GIVE CONSENT FOR MY CHILDREN TO ATTEND FAITH FORMATION CLASS AT ST. IRENAEUS \_\_\_\_\_  
Parent/Guardian signature

I hereby authorize the making of photographs, motion pictures, video tapes, recordings, or other memorializing of said event and my child's participation therein, and the publication and duplication or other use thereof. I hereby waive any rights to compensation or any right that I otherwise might have to limit if to control such making or use. \_\_\_\_\_  
Parent/Guardian signature

EMERGENCY INFORMATION

PLEASE LIST ADULTS YOU WOULD AUTHORIZE TO TAKE YOUR STUDENT(S) FROM THE CHURCH PREMISES, (OTHER THAN CHILD'S PARENTS), IN THE EVENT OF A MAJOR DISASTER. STUDENTS WILL REMAIN AT CHURCH UNTIL RELEASED TO A PARENT OR OTHER AUTHORIZED ADULT AS LISTED BELOW.

Name \_\_\_\_\_ Home Number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Number \_\_\_\_\_ Cell Phone \_\_\_\_\_

CONSENT TO THE TREATMENT OF A MINOR

The undersigned parent(s) of students (minors) registered in the Youth Faith Formation Program (YFFP) do hereby give consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment as authorized by St. Irenaeus YFFP at any accredited hospital in time of any special emergency or medical disaster. It is understood that this authorization is given in advance of any specific diagnosis, but given to provide authority to any diagnosis, treatment or hospital care which the Physician in the exercise of his/her best judgment may deem advisable. This authorization will remain in effect until the end of the school year.

\_\_\_\_\_  
(Parent/Guardian signature)

OFFICE USE ONLY

Notes:

Year										
Amount Due										
Payment Received										
Date Registered										

