St. Rita of Cascia Parish
CONFIRMATION REGISTRATION FORM — YEAR 1 (2011-2012)

Candidate Information

Student Name: _____
Last First Middle

School Attending in Fall '10_____ Grade _____ Date of Birth:_____

Address:_____

City: _____Zip: _____Cell Phone:_____

Email:_____T-Shirt Size (Circle One): XS S M L XL XXL

Please Attach Photo

Religious Information

Baptism** Date:_____ Church: _____
Address:_____
First Communion**Date:_____Church:_____
Address:_____
****Copy of original certificate required , including sacraments received at St. Rita**
Is family registered at St. Rita? No___ Yes___ Envelope #:_____ Mass attending (day/time)_____

Parent/ Guardian Information

Father / Guardian Info (address if different than above):

Name:_____
Address:_____
_____
Email Address: _____
Home phone: _____
Work phone: _____
Cell phone: _____
Religion: _____

Marital Status: S M D W RM

Mother / Guardian Info (address if different than above):

Name:_____
Address:_____
_____
Email Address: _____
Home phone:_____
Work phone:_____
Cell phone:_____
Religion:_____

Marital Status: S M D W RM

Agreement

Parent/Candidate Commitment Agreement — We have read the program requirements and agree to be committed to the St. Rita's Confirmation Preparation Program by making it a priority to attend the required sessions, one-day retreat, and weekly Masses, including the semi-monthly Saturday 5:30 p.m. Youth Mass on the first and third Saturdays of the month. Candidate's Signature_____

Father's Signature_____ Mother's Signature_____

Fees/ Deadlines

Fees: $90 for Early Bird registration received by June 30, 2011
$100 for Regular registration received by August 31, 2011
$110 for Late registration received after August 31. 2011
$175 for unregistered parishioners
10% discount for each additional family member.
Fees are non-refundable.

Check payable to St. Rita Catholic Church (Checks to be deposited after 07/01)

Please submit form and payment to:
Confirmation Program, 50 East Alegria Avenue, Sierra Madre, CA 91024

FOR OFFICE USE ONLY

Date Received: _____
By:_____
Paid: _____
Cash/Check #_____
Medical Release: _____
Baptism Cert.:_____
1st Communion Cert.:_____

St. Rita of Cascia Parish

CONFIRMATION REGISTRATION PROCESS

RELEASE FOR MEMORIALIZING:

I, hereby, authorize the making of photographs, video, recordings, or other memorializing of said event and my child's participation therein, and the publication or other use thereof. I, hereby, waive any right to compensation therefore or any right that I otherwise might have to limit or control such making or use.

Parent/Guardian Signature_____Date_____

EARTHQUAKE/DISASTER INFORMATION:

In the event of a major earthquake or disaster, your child will be held on the parish grounds and only be released to a parent/guardian or those adults listed below:

1._____

Name Address City Phone

2_____

Name Address City Phone

I hereby give consent for these adults to take my son/daughter home if I am unable to do so. I have notified each of them regarding this permission:

Parent/Guardian Signature_____Date_____

Emergency out-of-state phone number to be used if local numbers cannot be reached:

Contact Name_____Phone_____

FOR OFFICE USE ONLY:

Minor was picked up by:

_____

Name Date Office Signature

_____

Name Date Office Signature

St. Rita of Cascia Parish

CONFIRMATION REGISTRATION PROCESS

HEALTH AND MEDICAL RELEASE FORM FOR YOUTH

Name_____ **Date of Birth**_____
Address_____ **Female**_____ **Male**_____
City_____ **Zip**_____ **Phone (____)**_____

Is this participant in general good health and able to participate in all activities involved in this event?

YES_____ NO_____(If no, please submit a statement indicating limitations or serious medical conditions.)

Date of most recent physical exam: _____Physician or Clinic:_____

Address_____ Phone: (_____)_____

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IMMUNIZATION HISTORY: (Please give dates)

DPT_____ DPT BOOSTER_____ TETANUS BOOSTER_____

ALLERGIES (Please write yes or no next to each)
Hay Fever_____ Asthma_____ Poison Ivy_____ Sulfa_____ Nuts_____
Penicillin_____ Bee Sting_____ Other_____

Medicines_____
If any of the above is yes, please submit a statement of how the child has been treated and with what medication. Any medication not able to be self-administered must be listed.

Operations or Serious Injuries:_____ Dates:_____
Please notify the event coordinator if this child is exposed to any communicable disease during the three weeks prior to activity.

Does the participant have any special dietary needs? If yes please list on reverse side of form.

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AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s) of _____a minor, do hereby authorize as agent(s) **Theresa Costanzo or other adult catechists in the St. Rita Confirmation program,** for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act of the medical staff of any licensed hospital whether such diagnosis of treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our for said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.
I agree that in the event my child is injured as a result of his/her participation in this event, including transportation to and from such activity through the negligence (active or passive) of the **St. Bede the Venerable parish**, or any of any of its agents or employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, medical insurance, or any available benefit plan of mine or my spouse.

I also, give my child permission to self-medicate except for medications which are listed on the back of this form. I understand that any medications so listed will be dispensed by the Director of First Aid for the Confirmation Preparation Program.

This authorization shall remain effective immediately.

Signature of parent(s)/guardian:_____Date:_____

Emergency Telephone Number During Event (_____)_____ Alternate Telephone (_____)_____

Family Health Insurance Co:_____Policy No._____
(If possible please provide a copy of the insurance card)

Medication Name:_____

Dosage:_____

Frequency given:_____

Other Information:_____

Please list any special dietary needs: