SAINT MAXIMILIAN KOLBE FAITH FORMATION

5801 Kanan Rd. Westlake Village, CA 91362 (818) 991-3915 X113

*We understand that by registering our teen(s) in Confirming Disciples, we are making a commitment to **support the parish** by means of **regular financial contributions** and by **volunteering our time to the parish**. We are also **committing to attend Mass regularly** and **participating as required** in the Confirming Disciples Progcess.*

*Parent Signature*________________________________ *Date*________________________________

2017-2018 CONFIRMING DISCIPLES REGISTRATION FORM - *YEAR 1*

Family Name:____________________Home Phone:____________________E-Mail____________________

Address:______________________________City:____________________Zip:______________

Father's Name____________________Cell #:____________________Religion:____________________

Mother's First & *Maiden* Name:______________________________ Cell #:______________________________

Religion:____

Is there anything we should know about special living arrangements, etc.______________________________

____

TEEN(S) REGISTERING (CONFIRMATION ONLY) Year 1	SEX m/f	DOB mo/day/yr	GRADE 2017-18	SCHOOL attending	LAST FAITH FORM grade attended	SACRAMENTS RCVD. YES OR NO BAP	REC	COMM	CONF

Church of Baptism:____

Name **City** **State**

Date of Baptism:______________________________ Date of First Holy Communion______________________________

Church of First Holy Communion:____

Name **City** **State**

PLEASE PROVIDE A COPY OF EACH CANDIDATE'S BAPTISM CERTIFICATE WITH THIS FORM

2017-2018 TUITION, CONFIRMATION YEAR 1

ONE TEEN- $135.00 DUE @ TIME OF REGISTRATION
TWO TEENS- $220.00
THREE TEENS- $305.00

***AN ADDITIONAL RETREAT FEE WILL BE DUE @ TIME OF RETREAT**.

FOR OFFICE USE ONLY, PLEASE DO NOT FILL OUT.

*TUITION PAID*____________________

*DATE & CHECK #*____________________

*AMOUNT DUE*____________________

*DATE & CHECK #*____________________
BAP CERT ________ *PER SLIP* ________

ST. MAXIMILIAN KOLBE CATHOLIC CHURCH

5801 Kanan Road • Westlake Village, CA 91362 • (818) 991-3915 ext. 152

Amy Laliberte, Faith Formation Director amy@stmaxchurch.org

FAITH FORMATION
PERMISSION SLIP / MEDICAL RELEASE FORM

PARENT/GUARDIAN CONSENT FORM/WAIVER OF CLAIMS AND MEDICAL INFORMATION/AUTHORIZATION FOR PARTICIPATION IN EVENTS AND/OR ACTIVITIES SPONSORED BY ST. MAXJMILIAN KOLBE FAITH FORMATION AT ST. MAXIMILIAN KOLBE PARISH.

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PRINT YOUTH'S LAST NAME, FIRST NAME

has my permission to participate in Faith Formation sponsored events and/or programs at St. Maximilian Kolbe Parish for the period from August 01, 2017 – August 31, 2018.

I agree to direct my son/daughter to cooperate and to conform to the directions and instructions of the St. Maximilian Kolbe (SMK) Faith Formation personnel and volunteers in charge of activities, and I understand that transportation for my daughter/son to Faith Formation sponsored events will be provided by the Participant's respective Parent/Guardian.

I also give permission for my son/daughter to be photographed at Faith Formation activities and possibly be posted on the St. Max's Web Site, parish bulletin or on posters at St. Max's.

I, the undersigned, hereby release St. Maximilian Kolbe, agents, representatives from all liability arising out of or in connection with all St. Maximilian Kolbe Faith Formation activities. For the purpose of this agreement, liability means all claims, demands, losses, causes or action, suits or judgments of any and every kind that I, my heirs, executors, administrators or assignees may have against St. Maximilian Kolbe, or that any other person or entity may have against St. Maximilian Kolbe because of death, personal injury, or illness, or because of any loss or damage to property that occurs during any activities and that results from any other cause other than negligence.

Should it be necessary for my son/daughter to require medical testing and/or treatment while participating in events sponsored by St. Maximilian Kolbe Faith Formation in which I (Parent/Legal
medical treatment deemed necessary and appropriate by the physician. I understand that any insurance benefits that are active have limited application.

I have read and understand the foregoing statements and agree to assume the responsibilities stated above.

Parent/Legal Guardian Signature:__________________________Date:__________________________________

Participant's Address:___________________________________City:___________ Zip:____________

Participant's Home Phone #:_____________________Participant's D.O.B.:____________________________

Parent/Legal Guardian Work Phone or Cell#:____

Emergency Contact Person (other than parent): ____

Emergency Contact's # (home):______________________(work/cell):____________________________

Family Physician:_________________________________Phone #:_____________________________

Medical Group Coverage:___________________Group/Member Number:_______________________

*** Please be aware of the following medical condition(s) for my son/daughter listed here:**

Does your child have allergies? Yes_____ No____ If yes, please list______________________________