Our Lady Queen of Peace

Religious Education Program

Family Circle & Catholic Foundations

Family Name:_____ We are currently in Circle: #_____ or Home Based ◯

Parent Information:_____ & _____

Email_____- _____

Phone Number_____-_____

Address_____

- Street City State Zip Code

Children participating in the program (Name and grade):

_____ _____ _____ _____

I would like to participate in ◯ Family Circle+ Foundation Class or ◯ Home Based + Foundations Class

*__Family Circles__ meet according to group consensus *__Home Based__ works independently

*Foundation Classes meet the __1st Saturday of the month from October to May__

◯ I understand that participating in the program requires a one-time parent training session to fully understand the program objectives, and to be made aware of available resources.

My child(ren)'s picture may be taken ◯ Yes ◯ No

EMERGENCY INFORMATION

Person to contact in case of emergency (if parents are unavailable):

Name_____ Relationship_____

Phone (Home)_____ (Cell)_____

Please, list any medical or other information you feel we should know(e.g., asthma, allergies, diabetes, learning disabilities, etc)_____

MEDICAL RELEASE

I agree to indemnify Our Lady Queen of Peace Church, Youth Ministers, Volunteers and the Diocese of Arlington for any costs or expenses arising out of my child's participation in the activities including the cost of any medical care given my child or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by my child in the course of his or her participation in the activity.

I further give my consent to that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Parent signature: _____ Date: _____

CATHOLIC DIOCESE OF ARLINGTON PHOTO, PRESS, AUDIO AND ELECTRONIC MEDIA RELEASE

I authorize the Catholic Diocese of Arlington, its parishes and/or schools to use and publish the photographs and/or motion picture of videotape for which my child has posed, and/or audio recordings made of his/her voice. I agree that the Catholic Diocese of Arlington, its parishes and/or schools may use such photographs of my child with or without his/her name and for any lawful purpose, including, for example, such purposes as publicity, illustration, bulletin and Web content.

Parent signature: _____ Date: _____