

St. Jude the Apostle Catholic Community

Year 1 Confirmation Packet

Confirmation Coordinator: Lucia Bartlett
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Confirmation at St. Jude celebrates the Holy Spirit working in the hearts of young people. The Confirmation process is a time of discernment for our teens to explore, challenge, grow and eventually take ownership of the Catholic Faith. The process involves not only the teens, but the whole family and entire parish community. Confirmation is a two year process which starts in their Freshmen, Sophomore, or Junior year of high school.

How to Register for Confirmation

- Complete the online registration form which can be found at: <http://www.saintjudetheapostle.org/Confirmation-Program>

Please also complete and return the following to the Parish Office:

- All included permission forms
- Copy of BAPTISMAL certificate
- Check made payable to St. Jude the Apostle or payment made on We Share through the online registration process

The full calendar and expectations will be emailed to you once your entire registration has been completed and received.

Mark Your Calendars

(the following dates are mandatory)

- **Parent and Candidate Orientation:** Sunday, September 9th at 4:00pm OR Wednesday, September 12th at 6:15pm (Pick One)
- **Confirmation Nights** begin September 16th from 6:30-8pm
- **Year 1 Retreat:** January 18-20th, 2019



STUDENT AND YOUTH ACTIVITY PERMISSION FORM

School/Parish/Other Archdiocesan Sponsoring Entity ("Location"): St. Jude the Apostle Catholic Community

Place of Event/Trip: St. Jude the Apostle Catholic Community from August 1, 2018 - August 1, 2019

Activity: Field Trip [] Retreat [] Other (specify) _____ Purpose: Faith Formation/Fellowship

Description of Activity: Confirmation and Youth Ministry Activities See Attached: []

Mode of Transportation: Walk [] Car Pool [] Bus [] Other (specify) own transportation to Parish

Teacher/Adult Leader: Lucia Bianchino-Bartlett Attire: Casual attire and shoes

Minor's Name: _____

Address: _____

Date of Birth: _____ Male [] Female [] Grade _____

I request that my child be permitted to participate in the above activity. I am not aware of any physical or medical condition my child has that would prevent my child from participating fully in this activity.

My son/daughter has the following medical needs, allergies or dietary restrictions _____

If my child needs to take medication while participating in this activity, I hereby give my child permission to self-administer his/her medication in accordance with the Medication Authorization and Permission Form, and, if my child cannot self-administer, I give permission to the responsible staff members or chaperones to administer or to assist in the administration of my child's medication. I also give permission to the responsible staff members, chaperones, medical practitioners and medical facilities to use their judgement in obtaining and providing medical treatment for my child should it become necessary to do so. I understand that health insurance benefits through the Location, if any, may have limited application, and that I am entirely responsible for the cost of all medical treatment provided to my child. I agree to reimburse the Location for the cost of any medical treatment and related expense incurred.

Release of Liability: As a condition of participating in this activity, I hereby hold harmless, release and discharge The Roman Catholic Archbishop of Los Angeles, a corporation sole, Archdiocese of Los Angeles Education & Welfare Corporation and the Location, their respective agents and employees and any parent/volunteer/chaperone, from any and all liability, loss or claims for personal injuries, wrongful death or property damage that I or my child may suffer as a result of participation in the activity described above.

Parent/Guardian _____ Date _____

Home Phone _____ Cell Phone _____ Work Phone _____

Person to Notify in case of Emergency if Parent or Guardian is unavailable:

Name: _____ Phone: _____

Health Insurance Company: _____ Policy No.: _____

To be filled in by Location

To be filled in by parent/guardian

St. Jude the Apostle Catholic Community

Confirmation

Photo Release

I, _____, give consent to St. Jude Catholic Church the right to photograph my child(ren) which is sometimes displayed publically on the parish website, class slideshows and parish bulletin. I understand that these photos can be viewed by anyone, but no identifying information will be displayed.

PLEASE CHECK BOX IF YOU DO NOT GIVE PERMISSION

Please Initial _____

I Understand:

- In Confirmation, I recognize that I am the primary catechist in sharing the Catholic faith with my teen and as the parent; I play a vital role in my teen's faith formation.
- Regular Mass participation and attendance is a significant part of faith formation for my teen. _____ INITIAL
- Attendance at Confirmation Nights and Youth Nights is important. Teens with more than 1 absence will be asked to repeat the year again. _____ INITIAL
- Teens are required to attend a Confirmation Retreat. If my teen is unable to attend the St. Jude retreat, I will contact Lucia Bartlett to find out about other retreat opportunities through other parishes. _____ INITIAL

Parent/Guardian Signature: _____

Date: _____

**VIRTUS® “Teaching Touching Safety” Children’s Program
Archdiocese of Los Angeles**

TO: *Parents/Guardians*
FROM: *St. Jude the Apostle Catholic Community, Faith Formation*
SUBJECT: *VIRTUS® Touching Safety Program for Children and Young People*
DATE: *2018-2019 Formation Year*

St. Jude Faith Formation will present a child sexual abuse prevention program, called VIRTUS® *Touching Safety* to our students. They will also learn about internet and technology safety, setting boundaries, bullying and related topics. The program is a required element of religious education in the Archdiocese of Los Angeles.

This program is provided by Archdiocese of Los Angeles, and is a part of our ongoing effort to help create and maintain a safe environment for children and youth to protect all children from sexual abuse. We must give our children the tools they need to overcome the advances of someone who intends to do them harm.

The *Touching Safety* program will be taught by a trained instructor and will take place during one class session. It is designed for specific age groups: Grades K-2, Grades 3-5, Grades 6-8 & Grades 9-12.

**As a parent you have the right to decide whether or not your child can take this class.
Please complete this form and return it with your child’s registration.**

- YES:** I would like my child(ren) to participate in the Protecting God’s Children “Touching Safety Program.”
- NO:** I do not want my child to participate in the Protecting God’s Children “Touching Safety Program” and I will need to sign an “Opt Out” form.

Child’s Name: _____

Child’s Name: _____

Child’s Name: _____

Child’s Name: _____

Parent’s Name (printed): _____

Parent’s Signature: _____

Date: _____



St. Jude the Apostle

YEAR 1 CONFIRMATION RETREAT

JANUARY 18TH-20TH, 2019

Retreat forms must be returned by November 16th.

Where: Gindling Hilltop Camp, Malibu

When: January 18 – 20, 2019

Time: Leaving Friday at 4:00pm

Returning to St. Jude on Sunday at 12:15pm

Transportation by bus is provided.

Further details including items to bring will be emailed to those registered.





STUDENT AND YOUTH ACTIVITY PERMISSION FORM

LOCATION: GINDLING HILLTOP CAMP - MALIBU, CA
Minor's Name:
Address:
Date of Birth: Male Female Grade
Activity: Field Trip Retreat Other (specify)
Date(s) of Activity: JANUARY 18-20, 2019
Cost: \$150
Purpose: YEAR 1 CONFIRMATION RETREAT
Description of Activity: DEPART FRIDAY @ 4:00PM - RETURN SUNDAY APPROX @12:15PM See Attached:
Mode of Transportation: Walk Car Pool Bus Other (specify)
Teacher/Adult Leader: LUCIA BARTLETT Attire: CASUAL

I request that my son/daughter be permitted to participate in the above activity. My son/daughter has no medical condition that would render it inappropriate for him/her to participate in this activity. My son/daughter has no known medical needs, allergies or dietary restrictions except as follows:

Should it be necessary for my son/daughter to take medication while participating in this activity, I hereby give my son/daughter permission to self-administer his/her medication in accordance with the Medication Authorization and Permission Form, and, if my son/daughter cannot self-administer, I give permission to the responsible staff members or chaperones to administer or to assist in the administration of my son/daughter's medication. I also give permission to the responsible staff members, chaperones, medical practitioners and medical facilities to use their judgement in obtaining and providing medical treatment for my son/daughter should it become necessary to do so. I agree to relieve the Location and participating adults from liability in connection with this request. I understand that the insurance benefits through the Location, if any, may have limited application, and that I am entirely responsible for the cost of all medical treatment provided to my son/daughter. I agree to indemnify and hold the Location harmless from the cost of any medical treatment and related expense and cost incurred.

Release of Liability: As a condition of participating in this activity, I hereby hold harmless, release and discharge The Roman Catholic Archbishop of Los Angeles, a corporation sole, Archdiocese of Los Angeles Education & Welfare Corporation and the Location, their respective agents and employees and any parent/volunteer/chaperone, from any and all liability, loss or claims for personal injuries, wrongful death or property damage that I or my son/daughter may suffer as a result of participation in the activity described above.

Parent/Guardian Date

Home Phone Cell Phone Work Phone

Person to Notify in case of Emergency if Parent or Guardian is unavailable:

Name: Phone:

Health Insurance Company: Policy No.:



**Archdiocese of Los Angeles
Medication Authorization and Permission Form**

Location: Gindling Hilltop, Malibu for Year 1 Confirmation Retreat

Part A to be completed by a licensed physician unless copy of prescription and original prescription bottle is provided containing the information requested in Part A.

I hereby request that my son/daughter be allowed to take the following medication(s) at the Location identified above and/or at a Location sponsored field trip, event or activity.

Last Name of Minor	First Name	Sex	Birth Date
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Name of Medication: _____

A. Physician's Instructions. (Complete where applicable)

Purpose of Medication or Diagnosis

Dosage Prescribed	Date/Time Schedule	Dose Form (tablet/liquid)
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Please notify this office if patient misses medication Yes No

Medication may have adverse effects (explain) _____

Special instructions and/or comments: _____

Print Name of Licensed Physician	Signature of Licensed Physician	Date
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Physician Address and Phone Number

B. Permission for Administration of Medication and/or Testing at Location and/or at Location sponsored Field Trip/Event/Activity: I request that my son/daughter identified above, be permitted to carry and use emergency medication (inhaler, epi-pen, insulin, etc.) and/or test for levels of blood sugar at the Location identified above and/or at a Location sponsored field trip/event/activity as prescribed by the physician above. I acknowledge and understand that no health care professional or other trained adult may be available at the Location or at the field trip/event/activity to assist, monitor or supervise my son/daughter's self-administration of medication or testing unless arrangements have been made in advance. In the event that my son/daughter is unable to self-administer or self-test, I agree that Location staff/chaperones may assist my son/daughter to the extent possible under the circumstances, but neither they nor the Location shall be liable for any adverse consequences or injury. I hereby give the Location staff/chaperones permission to call paramedics to render treatment to my son/daughter should that be necessary and to release medical information to first responders for that purpose. For all other medications, my son/daughter and I will comply with the Location's policies and procedures and will provide the Location with any medication my son/daughter requires in its original prescription bottle.

Parent/Guardian Name: _____ **Emergency phone number:** _____

Parent/Guardian Signature: _____ **Date:** _____