St. Peter Claver Youth Ministry

5649 Pittman St., Simi Valley, CA 93063-3525
www.spcym.org/confirmation.html
youthministry@saintpeterclaver.org
(805) 526-7975

2018-2019 Youth Registration Form

Registrant's Name:_____ _____(_____)
First Middle Last Goes By (if different)

Sex: M F Birth date: ____ /____ /____ T-Shirt Size (Adult):_____ Grade:_____

Registering for (please check one):

☐ Youth First Communion ☐ Youth Ministry ☐ Middle School YM

Home Address:_____
Street City State Zip Code

Registrant's Mobile Phone # (if any):_____ Mobile Phone Carrier:_____

Registrant's Email Address (if any):_____

Current School:_____

Sacraments this registrant has <u>already</u> received:

☐Baptism (Date:_____, Parish:_____, City:_____, State:____)

☐First Reconciliation ☐First Communion ☐Confirmation

Father/Guardian's Information		**Mother/Guardian's Information**
	Name	
	Goes by	
	Street Address	
	City, State, Zip	
	Home Phone #	
	Occupation	
	Employer	
	Work Phone #	
	Mobile Phone #	
	Mobile Phone Carrier	
	Email Address	
	Language(s) Spoken	
	Religion	
	Place of Worship	
	Registered Parishioner?	
	Church Envelope #	
	Parish ministries you participate in (if any)	
	Stepmother/Stepfather	

Youth Health and Medical Form

Youth's Name _____ Sex: M F Birth date: ____ /____ /____

Youth's Physician or Medical Clinic: _____ Phone Number:_____

Address:_____

Medical Insurance Carrier:_____ Name of Policy Holder:_____

Identification Number(s) (ID#, Record#, Member#, Group#, etc.) _____

Please list any allergies that your child has (medical, food, environmental, etc.) and indicate treatment (if any):

Allergy Reaction Treatment (if any)

_____

Does your child have any special dietary needs or restrictions? Do they have any food sensitivities or allergies? Are they a vegetarian or vegan? Please explain below:

_____

Youth Medication Authorization and Permission Form

A. <u>Prescription Medication</u> (if applicable)

I hereby request that my son/daughter identified above be allowed to take the following prescription medication(s) at the Location identified above and/or at a Location sponsored field trip, event, or activity. <u>I will provide prescribed medication(s) to the Location in their original pharmacy bottle or box with prescription information attached for events as needed..</u>

1. Name of Prescribed Medication:_____

   _____ _____

   Dosage Prescribed Date/Time Schedule

2. Name of Prescribed Medication:_____

   _____ _____

   Dosage Prescribed Date/Time Schedule

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

B. <u>Over-the-Counter Medication</u>

I hereby request that my son/daughter identified on Page 1 of this form be allowed to take the following over-the-counter medications at the Location identified on Page 1 and/or at a Location sponsored field trip, event, or activity. Please <u>check all that apply</u>:

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil) ☐ Naproxen (Aleve)

☐ Diphenhydramine HCL (Benadryl) ☐ Polysporin (Antibiotic Ointment) ☐ Tums

☐ Phenylephrine HCL (Decongestant) ☐ Calamine with Pramoxine HCL (Caladryl Lotion)

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date