REGISTER NOW! FAMILIES IN RELIGIOUS EDUCATION

K-12 Faith Formation • Registration • 2023-24

Family: Last Name _____ Family Email _____

Phone #1/ Name: _____ Phone #2/ Name: _____

Below: Please list household members ***(first names)*** who will be involved in FIRE. Add last name if different from above.

Name	Grades K- 12 & Adult	Name	Grade (K- 12)

TUITION

Adults (Only K – 6th) $25.00 each _____

Youth (K-12th) $75.00 each _____

The tuition cap is $175 per family. Scholarships are available.

****There are no fees for Confirmation or 1st Communion & Reconciliation preparation.****

Pay it forward: To assist families in need, we have included a gift of _____

No family is denied participation in the FIRE program due to financial hardship. Please contact: Wendy Rappé or Mammas Mammas if assistance would be helpful. **Discount to volunteers** upon request.

Methods of payment: we accept cash, check (*please make checks out to Christ Our Light*) or card (*online only: www.christourlightmn.org click on "give" link, then green "donate online." Processing fee applies.*)

FIRE meals will be provided on Wednesdays at 5:45 – 6:15PM.

To help defray expenses a $5 donation is recommended. Thanks!

_____ Check here if you are NOT a registered member and need to attend a Member Orientation Session.

(Non-Registered participants are asked to pay a fee of $100.00 that will be returned upon attending a Member Orientation Session. (Please make out a SEPARATE check for this.)

PLEASE SUBMIT ADDITIONAL COPIES, IF NEEDED, FOR EACH CHILD.

MEDICAL RELEASE FORM – CHRIST OUR LIGHT CATHOLIC CHURCH

I hereby warrant that to the best of my knowledge, my youth is in good health,
and I assume all responsibility for the health of my youth.

Youth Name(s):_____

Parent Name:_____

Parent Signature:_____ Date:_____

→ → *(Of the following statements pertaining to medical matters, sign only those that are applicable.)* ← ←

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my youth to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me, please contact:

Name & relationship: _____ Phone: _____

Physician: _____ Phone: _____

Health Insurance Co.: _____ Policy #: _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Saint Cloud, chaperones, or representatives associated with the activity that my youth becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called at this number:____

Non-prescription medication: I hereby grant permission for **non-prescription medication** (such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my youth.

Signature: _____ Date:_____

Medications currently taken (prescription & non-prescription) and include dosage:

_____

Specific Medical Information: The parish will take care to see that this information will be held in confidence. You should be aware of these medical conditions of my child (any allergies, special needs, dietary restrictions, disabilities, emotional concerns, existing medical conditions, etc.)

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