St. Bernard CCD Program

Registration

School Year ______________ /________________

Please complete the following information below for your child/children that will be attending the St. Bernard CCD Program for the school year indicated above. One registration per family. Thank you! *Registration Fees: check with CCD Director*

Name:	Grade:	Gender:
Student's #1:		M / F
Student's #2		M / F
Student's #3		M / F
Student's #4:		M / F
Student's #5		M / F
Student's #6:		M / F

Father's Name: *(first & last)* ____________________

Mother's Name: *(first & last)* ____________________ *(Maiden)* ____________________

Mailing Address: ____________________

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Email: ____________________

Parish: ____________________

Primary Phone: ____________________ **Texting** Yes / No

Secondary Phone: ____________________ **Texting** Yes / No

Please indicate on the lines below if any of your child(ren) have any special needs for the classroom so we may inform and assist our teachers so they can best educate your child(ren):

____

____

I am interested in volunteering for one of the following:

________ Teacher ________ Substitute ________ Classroom Aide

By my signature, I authorize the St. Bernard CCD Program to enroll my son/daughter into the religion program on Wednesday evenings. I understand the importance of my child's religious education and will help to instill the values taught within the program.

Signature: **Date:**

PERMISSION, RELEASE, AND AUTHORIZATION TO SEEK MEDICAL TREATMENT FORM (rev. 7-9-2020)

1. I, the custodial parent/legal guardian of ______________________________________(the "Child"), give permission for my Child to participate in the activity described on the *Activity Information Form* (the "Activity") and release from all liability, indemnify, and hold harmless ***ST. BERNARD CCD*** (print name of parish and school) ("Parish and School"), the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese, all parishes and schools within the Archdiocese, and all of their agents, representatives, volunteers, and employees from any and all liability, claims, judgments, damages, costs and expenses, including attorneys' fees, arising out of any injury, illness, infectious and/or communicable disease (such as MRSA, influenza, or COVID-19), or death, (including any injury, illness, infectious and/or communicable disease, or death caused by the negligence of Parish and School, the Archbishop, the Archdiocese, any parish or school within the Archdiocese, or any of their agents, representatives, volunteers, or employees) incurred by my Child while participating in the Activity, traveling to or from the Activity, or while using the facilities and equipment of the Parish and School. I further agree not to bring or prosecute or allow to be brought or prosecuted (including, but not limited to, prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits, or actions against Parish and School, the Archbishop, the Archdiocese, all parishes and schools within the Archdiocese, or their agents, representatives, volunteers, and employees.

2. I understand that my Child's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks of injury, illness, infectious and/or communicable disease (such as MRSA, influenza, or COVID-19), and death. I agree that if my Child has underlying heath concerns which may place him/her at greater risk of contracting COVID-19 or that would possibly increase the severity of illness if COVID-19 is contracted, then my Child and I will consult with a health care professional before participating in the Activity.

3. I agree to instruct my Child to cooperate with the agents of Parish and School and/or the Archdiocese who are in charge of the Activity.

4. I authorize the agents of Parish and School and/or the Archdiocese who are acting as leaders of the Activity to seek medical treatment for my Child in the event of any injury, illness, or medical emergency during the Activity or related travel. I understand that the agents of Parish and School and/or the Archdiocese will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my Child.

5. Please indicate. I ☐ agree ☐do not agree that Parish and School and/or the Archdiocese may use my Child's portrait or photograph for promotional purposes, website, and office functions.

Please indicate. I ☐ agree ☐ do not agree that Parish and School and/or the Archdiocese may use social media and technology to communicate with my Child regarding parish/school related ministry activities.

6. This Permission, Release, and Authorization is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This Permission, Release, and Authorization shall be construed in accordance with the laws of the State of Ohio, excluding, and irrespective of, any choice of law principles to the contrary.

7. Parish and School, the Archdiocese, the Archbishop and their agents, employees, and volunteers shall have no liability whatsoever in the event the Activity is cancelled due, in whole or in part, to any present or future pandemic, epidemic, widespread disease or illness, public health concern, or circumstances arising therefrom, or from actions taken by any governmental or municipal authority to prevent, avoid, or mitigate the impacts thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Authorization to Seek Medical Treatment shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian______________________________________ Date ______ / ______ / ____

Place of Employment ______________________________ Phone: (w)____________________

Work Address ______________________________ City ________________ Zip__________

Phone: (home)________________ (cell)________________ (cell) ________________

Emergency Contact Name ______________________________ Phone ________________

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Medical Information – Completed by Parent or Guardian – PLEASE PRINT

Child's Name	Birth Date	Social Security#*	Allergies/Medications/Chronic Conditions (e.g. epilepsy, diabetes)

Medical Insurance Co. ______________________________ Policy No. ______________________

Member's Name ________________________ Phone: (h) ____________ (w) ______________

Member's Birth Date ______/______/________ Member's Social Security # * ______________________

Family Doctor ______________________________ Phone ______________________

***Social Security numbers are optional, but SHOULD NOT be emailed due to Personal Identifiable Information Act.**
(Please note that some hospitals WILL NOT treat without it.)