

MARY STAR OF THE SEA
Youth Ministry & Confirmation Program
870 W. 8th St.
San Pedro, CA 90731
(310) 833-3541 Ext. 220
2011 - 2012

Must be on file in order to Re-register:

- Baptism Certificate
- Sponsor Form
- Saint Report
- Sponsor Report

Registration Fee: \$180
Due at time of registration.

Year 2
REGISTRATION FORM

Part I (please print)

Student Last Name _____
First Name _____
Middle Name _____
Nick Name _____
Student Email _____
Student Cell # _____
High School _____
Grade _____ Birth date _____

Primary Parent/Guardian Name :

_____ First Last
Primary Contact (Home) Phone #

Primary Parent/Guardian Cell Phone #

Primary Parent/Guardian Email

Primary Address

Street: _____
Number Street Name Apt. #

City: _____ Zip: _____

Have you been Baptized? YES [] NO []

Have you made your 1st Communion? YES [] NO []

If you answered *no* to any of the above questions you will meet on Wednesday from 6-8:30pm (Do not fill out Part II)

Have you chosen a different Sponsor other than the one we have on file?

Yes, Please fill out a new *Sponsor Form* before turning in registration.

No

I need a sponsor.

Part II - Please number (1,2,3) your first, second and third choice below for your meeting day. Be sure that family, school, homework, and extra-curricular activities (sports in any season) **DO NOT** conflict. You will **NOT** be able to switch.

Wednesday Evenings [] 7:00 – 8:30 pm
Sunday Afternoons [] 3:00pm - concludes w/Mass
Other*: _____ []

*This is a TENTATIVE option based on interest and on catechists' availability.

The max for each day is 40 Students. We will try to honor all first choices if at all possible.

OFFICE USE ONLY

PLEASE DO NOT WRITE IN THIS BOX

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Payment \$ _____ Chk # _____ Receipt # _____ Date _____ Init. _____

FATHER'S INFORMATION Legal Guardian [] First Name _____
Last Name _____ Occupation _____
Cell Number _____ Work Number _____

E-mail _____ Home Phone (if different from students) _____

MOTHER'S INFORMATION Legal Guardian [] First Name _____
Maiden Name _____ Occupation _____
Cell Number _____ Work Number _____

E-mail _____ Home Phone (if different from students) _____

STEP-ARENT (If Applicable) Legal Guardian []
Name _____ Relationship to Child _____
Home Phone _____ Work Phone _____

EMERGENCY CONTACT if parents/guardians are not available
Relative/Friend's Name: _____ Relationship to Child: _____
Home Phone: _____ Work/Cell Phone: _____

PARENT AUTHORIZATION & MEDICAL RELEASE FORM

In consideration of the acceptance of my son/daughter in the Mary Star Youth Ministry Program of Mary Star of the Sea Parish, I hereby waive any and all claims for damages against Mary Star of the Sea Parish and its authorized personnel of any kind of character.

I, _____, having legal custody of _____,
(Parent/Guardian) (Student)

a minor, do hereby authorize as agents the authorities of Mary Star's Youth Ministry, into whose care said person is entrusted to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered to said person under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act of the medical staff of any licensed hospital whether such diagnosis of treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our for said agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective from: July 1, 2011 – September 1, 2012

Parent/Guardian's Signature _____ Date _____

Family Health Insurance Provider: _____

Cardholder's Name: _____ **and Policy No. :** _____

Doctor's Name: _____ Phone Number: _____

Any Medical/Physical Problems or Special Needs: _____

Any Allergies, Please List: _____