

**OFFICE OF FAITH FORMATION**  
**REGISTRATION FORM 2024 - 2025**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City & Zip Code

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Full Time School Entering in September: \_\_\_\_\_ Grade: \_\_\_\_\_ Sex: \_\_\_\_\_

Has your child previously attended Faith Formation? \_\_\_\_\_ Yes \_\_\_\_\_ No

How many years of instruction? \_\_\_\_\_ Where? \_\_\_\_\_

**FAMILY INFORMATION**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_  
Last First Maiden First

Father's Work phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Cell ( \_\_\_\_\_ ) \_\_\_\_\_ Email Address \_\_\_\_\_

Mother's Work phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Cell ( \_\_\_\_\_ ) \_\_\_\_\_ Email Address \_\_\_\_\_

Is your family registered in the parish? \_\_\_\_\_ Yes \_\_\_\_\_ No

If NO, where are you registered? \_\_\_\_\_

Father's religion: \_\_\_\_\_ Mother's religion \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Mother's Occupation \_\_\_\_\_

*Is there any health/educational information you would like to share with us about your child?*

Place and Date of Birth: \_\_\_\_\_

Place and Date of Baptism: \_\_\_\_\_

Has your child received any other sacrament(s), if so what sacrament(s)? \_\_\_\_\_

Registration Fee 1- child \_\_\_\_\_ 2 – or more \_\_\_\_\_  
\$25 \$50

\_\_\_\_\_ I do \_\_\_\_\_ I do not give permission for my child to be photographed and/or videotaped during ministry activities and events. I understand my child may decline to be photographed and/or videotaped at any time. This may be the resulting photographs and/or footage to be edited, if necessary and to be published and/or videotaped for promoting ministry and/or youth programs at St. Joseph.

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

**EMERGENCY INFORMATION:**

In case of a serious accident or serious illness, I request Faith Formation to contact me. I hereby authorize the Faith Formation to call the physician indicated below and to follow his/her instructions. If it is impossible to contact the physician, Faith Formation may make the appropriate arrangements for the care of my child.

Signature of parent or guardian: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: (\_\_\_\_\_) \_\_\_\_\_ Home Exchange (\_\_\_\_\_) \_\_\_\_\_

Hospital: \_\_\_\_\_

Name of two relatives who will assume temporary care of your child if you can't be reached.

**Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

**Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Do any of your children receive any Special Services at their school or after hours? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Child:** \_\_\_\_\_

**Child:** \_\_\_\_\_

**PLEASE NOTE THAT MY CHILD HAS SPECIAL MEDICAL NEEDS OR MEDICATIONS:**

Please list: \_\_\_\_\_

**ADULT VOLUNTEER OPPORTUNITIES:**

**We need substitute teachers to help out when our teachers are out. Please consider helping.**

I would like to volunteer to be a:     teacher \_\_\_\_\_ Co-teacher \_\_\_\_\_ teacher aide \_\_\_\_\_ substitute \_\_\_\_\_

Please contact me: Name \_\_\_\_\_