ENROLLMENT FORM

Form must be filled out and signed by the parent or guardian.

Totus Tuus is scheduled for
Monday, June 15th – Friday, June 19th
For students entering 1st grade – 6th grade
9:00 am to 3:00 pm
AND
Sunday, June 14th – Thursday, June 18th
For Jr/Sr High School students
7:30 pm to 9:45 pm

Name of Parent(s):_____

Address:_____

Best Phone Number:_____ Cell___ Home___

Email Address:_____

Children: _____ Grade entering in the Fall:_____

Children: _____ Grade entering in the Fall:_____

Children: _____ Grade entering in the Fall:_____

Children: _____ Grade entering in the Fall:_____

St. John's has my permission to use my child's photo/video to promote related activities in all print/online publications, presentations, websites, social media sites, etc.. YES___ NO___

Form B has to be filled out for each child.

Form C can be used for multiple children (if the insurance information is the same). Please list all children's names on the top of the form.

_____ _____

Parent/ Guardian Signature Date

Official legal form for the Diocese of Salina

FORM B - MEDICAL INFORMATION

This form should be completed for any person (under 19 years of age) in parish religious education, Catholic schools, and youth ministry programs and should be completed on an annual basis at the beginning of the program.

Diocese: Salina Parish _____ School _____

Participant's Name _____

Date of Birth_____ Place of Birth_____

Participants Regular Physician:
Name (first, middle, last): _____ Phone (including area code): _____

Medical Conditions:
Please list any medical conditions of the participant (asthma, diabetes, epilepsy, etc…): _____

_____

List below any physical condition the sponsors, doctors, nurses, or other medical personnel should be aware of:
Insect stings:_____ Fainting Spells:_____
Allergies:_____ Ear Infections:_____
Seizures:_____ Heart Condition:_____
Headaches:_____ Other:_____

List any allergies or allergic reactions to medications of the participant: _____

Other pertinent medical information: _____

Dates of Participant's last immunizations: MMR_____TB _____ TETANUS _____

Special dietary needs/restrictions: _____

Medications:
Prescribed medication now being taken:
Type: _____ Dosage: _____ How often: _____
Activities individual should not participate in: _____

Medical Insurance Information:
Company: _____
Plan Number: _____ Employee Identification #: _____

Emergency Contacts:

Parent or Guardian Name (first, middle, last): _____
Daytime Phone (including area code): _____ Evening Phone (including area code): _____

Other Contact:

Name (first, middle, last): _____ Phone (including area code): _____
Relationship (friend, neighbor, coworker, etc): _____

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Name (first, middle, last): _____ Phone (including area code): _____
Relationship (friend, neighbor, coworker, etc): _____

CATHOLIC DIOCESE of SALINA

FORM C – PARENT OR GUARDIAN MEDICAL CONSENT FORM AND LIABILITY WAIVER

Official legal form for the Diocese of Salina

***Form C** is to be used for any parish, Catholic school, youth ministry and diocesan field trips.*

Diocese: Salina Parish _____ School _____

Destination: _____

Name of Participant (Minor): _____

Home Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Business Phone: _____

Medical Matters

The parish/school/organization will take all reasonable and prudent care to see that confidentiality regarding the following information is maintained.

I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. I/We understand and acknowledge that any medical expenses related to illness or injury to my/our child are not covered by an insurance program maintained by the parish/school/organization or the Diocese of Salina, and that I/we are responsible for such expenses.

I/We understand that first aid will be available on the above-mentioned trip. I/We further understand that should an accident, injury or illness occur, medical and/or hospital care will be obtained. I/We realize the sponsors will make a reasonable effort to notify me/us in case of accident, injury, or illness; however, should they be unable to contact me/us, they have my/our permission to pursue a course of medical action which is in the best interest of the child.

I/We understand that a reasonable effort will be made to promptly notify me/us in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, in the event I/we cannot be reached, I/we hereby give permission to the physician or health care provider selected by the adult staff to hospitalize, secure proper treatment for, and order whatever injection, anesthesia, or surgery said physician or health care provider deems necessary for the child. A doctor, clinic, hospital, or health care provider may proceed with any medical or surgical treatment that such sponsor may authorize.

I further understand that I will be responsible for all medical, surgical, and transportation costs which may be incurred.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Insurance Information

Insurance Company: _____ Policy Number: _____

(If Blue Cross/Blue Shield Insurance, please state if it is Blue Choice, Blue Select, etc.)

Policy Holder: _____ Date of Birth: _____

Occupation: _____

Employer: _____ Employer Phone:_____

Employer Address: _____