



# K -12 Faith Formation Registration 2017-2018

Our Lady Queen of Peace, 601 Edgewood Ave., NY 14618

St Thomas More, 2617 East Ave., Rochester, NY 14610

244-3010 or 381-4200 **Contact:** Jodi Miller, Director of Faith Formation - [jodi.miller@dor.org](mailto:jodi.miller@dor.org)

**Registration Fee:**  
**\$40 per student**  
***Please make checks payable to Our Lady Queen of Peace.***

Family name \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_

Child's last name, if different \_\_\_\_\_

Mother's name \_\_\_\_\_ e-mail \_\_\_\_\_ work # \_\_\_\_\_ home# \_\_\_\_\_

Father's name \_\_\_\_\_ e-mail \_\_\_\_\_ work # \_\_\_\_\_ home # \_\_\_\_\_

*Are you considering preparing for  
any of the following sacraments  
during 2017-18?*

Name	School Attending	Grade	Birth date			
1. _____	_____	_____	_____	E	R	C
2. _____	_____	_____	_____	E	R	C
3. _____	_____	_____	_____	E	R	C
4. _____	_____	_____	_____	E	R	C

**CHOICE OF CLASS TIME - PLEASE CIRCLE YOUR SELECTION**

*K-5 Faith Formation*

**Tuesdays 6:00 - 7:15 pm at St. Thomas More**

*Junior High Faith Formation (grades 6-8)*

**Bi-weekly Sundays 6:30 - 8:30 pm at Our Lady Queen of Peace**

*Senior High Youth Group (grades 9-12)*

**Bi-weekly Sundays 6:30 - 8:30 pm at Our Lady Queen of Peace**

**SPECIAL NEEDS** Does your child have any special needs that we should be aware of? How can we best support your child?

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**IMPORTANT:** If you have a child registering for the first time in the faith formation, please return this form with a copy of the child's baptismal record. *(Please check if he/she was baptized at Our Lady Queen of Peace \_\_\_\_\_ or St. Thomas More \_\_\_\_\_. No baptismal certificate is required if this is the case.)*

Family Name \_\_\_\_\_

# FAMILY HEALTH FORM (K-12 GRADES)

Our Lady Queen of Peace/St. Thomas More

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Health Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_

Who should be notified in case of emergency if parent cannot be reached?

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Are you carpooling? To whom may the child be released when the program is over?

Name	Phone #	relationship
_____	_____	_____
_____	_____	_____

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1) Child \_\_\_\_\_

Please list any allergies or special needs \_\_\_\_\_

Medication(s) \_\_\_\_\_

2) Child \_\_\_\_\_

Please list any allergies or special needs \_\_\_\_\_

Medication(s) \_\_\_\_\_

3) Child \_\_\_\_\_

Please list any allergies or special needs \_\_\_\_\_

Medication(s) \_\_\_\_\_

4) Child \_\_\_\_\_

Please list any allergies or special needs \_\_\_\_\_

Medication(s) \_\_\_\_\_

In signing this health form, I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles for medical and other emergency purposes only, and for the release of medical records to an attending physician in case of illness.

In case of medication emergency I understand that every effort will be made to contact the parents or guardian. In the event that I cannot be reached, I hereby give permission to the physician selected to secure proper treatment for my child named herein.

Signature of parent/guardian: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date: \_\_\_\_\_