

C2 Confirmation information 2018 to 2019

*Please fill this form out and return it to by
Wednesday, October 24th, 2018*

*If you have any questions please contact Bryan at 651-621-1562
or by e-mail at bcollins@churchofstpatrik.com.*

Learner's full name as it will appear on the certificate of Confirmation:
(no shortened names please)

(Last)

(First)

(Middle)

Parent(s) or Guardian: _____

Church of Baptism _____ City _____
State _____

If not already provided: A photocopy issued within the last 6 months is required for all Sacraments. If your child was NOT Baptized at St. Patrick's please attach a PHOTOCOPY of their baptismal certificate.

Sponsor Information

Sponsor's Name: _____

Sponsor's address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

(C2 Only) Consent form for C2 Confirmation Retreat – **DUE OCT. 24**

Learner/Participant Name _____

Date of Birth _____ Sex _____ Grade 2017-2018 _____ School _____

Parent/Guardian Name _____

Home Address _____

Home Phone _____ Cell Phone _____

Date of Retreat April 6 and 7, 2019 Type of Retreat Confirmation

Destination Association Retreat Center, Osceola, WI

Individual(s)/Teacher(s) in Charge Bryan Collins

Estimated Time of Departure 10:00 AM on 4/6/19 Return 3:00 PM on 4/7/19

Mode of Transportation To & From Event School Bus

Learner Cost (if applicable) Included in Faith Formation Registration Tuition

I, _____, grant permission for _____
Parent or Guardian Name Child Name

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the Church of St. Patrick and the Archdiocese of St. Paul & Minneapolis from any claims or law suits brought against the Church of St. Patrick/Archdiocese of St. Paul & Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the parish/school and the Archdiocese in defense of such a claim/suit.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact _____
Name Phone Number

MEDICAL INFORMATION:
Medication my child is taking at present _____

Allergies _____

Other Medical Conditions _____

Family Health Plan carrier number _____

Family Doctor _____ Phone Number _____

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

Signature Date