

Date: \_\_\_\_\_

# **San Jose Middle School Youth Registration 2018 - 2019**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

Birth Date \_\_\_\_\_

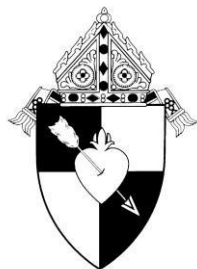
T-Shirt Size (circle one): S M L XL Other \_\_\_\_\_

Special Talent \_\_\_\_\_

Parent's Names & Cell (and/or Step-Parents) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Please complete all of our registration forms with a parent*



**Diocese of Saint Augustine**

Catholic Center

11625 Old St. Augustine Road

Jacksonville, Florida 32258

(904) 262-3200

***2018-2019 San Jose Youth Child Photography Release Form***

Without compensation, I hereby grant permission to the Catholic Diocese of Saint Augustine to use and reproduce photographs and/or video taken of my child. These photographs may be used for news and editorial purposes in publications and other electronic reproductions (websites and video) and/or brochures. In addition, I grant my permission to alter the same photos without restriction and to copyright the same. I hereby release the photographer, the journalists and the publications or media outlets they represent, as well as, the parish/church and/or school involved, the Bishop of the Diocese of St. Augustine, a corporation sole, the Catholic Diocese of Saint Augustine and all of their employees and agents, from all claims and liability relating to said photographs.

Child's Name (Printed): \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Date: \_\_\_\_\_



**Diocese of St. Augustine  
Parent Permission and Release of Liability  
San Jose Parish middle school youth night student waiver**

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

Parent / Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

(Of the following statements pertaining to medical matters, sign only in accordance with your wishes.)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to Diocese of St. Augustine's employees, volunteers, or representatives to seek medical treatment for my child above named.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Diocesan representatives or volunteers to hospitalize, secure proper treatment for, and to order injection and / or anesthesia and / or surgery for my child above named.

In the event of an emergency, if you are unable to reach me at the above number, contact:

Name and Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I make the following exception: \_\_\_\_\_

My Child's Medications / Dosages: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Doctor: \_\_\_\_\_

Medical Problem or Condition (allergies, diabetes): \_\_\_\_\_

Condition: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Physical Disabilities: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

OTHER MEDICAL TREATMENT: In the event it comes to the attention of the Diocese of St. Augustine's employees, volunteers or representatives that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date