ENROLLMENT FORM AND EMERGENCY INFORMATION

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

The cost of Totus Tuus will be $25 per child or $75 max per family.
Make checks payable to St. John's Church, with "Totus Tuus" in the memo.
(Financial Scholarships available – contact the parish office!)

Totus Tuus

Grade School Program – Monday, June 15 – Friday, June 19
Junior High/High School Program – Sunday, June 14 – Thursday, June 18

Grade School Program (Current 1st – 6th Graders) Mon.-Fri. 9:00 am – 3:00 pm*
Junior High/High School Program (Current 7th – 12th Graders) Sun. – Thurs. 7:30 pm – 9:45 pm*

Name of Parents_____

Address _____

Best Phone number _____ Cell___ Home___

Email address(es) _____

Children: _____Current* Grade _____

_____Current* Grade _____

_____Current* Grade _____

_____(*Just recently completed) Current Grade _____

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___

While your child/children are in our care it is important for us to have the following information:

Whom should we contact in case of an emergency? *(Only if different from above...)*

Name_____Phone _____

Is there any medical information that we need to know about your child? YES____ NO____
Are any of your children currently taking medications? YES ____ NO ____

Please list any medical/special needs, medications, allergies (medicine or food), or disability (if applicable) for each child.

Name	Medication	Dosage	Medical Condition	Other Special Needs
1.				
2.				
3.				
4.				

MEDICAL TREATMENT AUTHORIZATION

I UNDERSTAND THAT I/WE WILL BE NOTIFIED IN THE CASE OF A MEDICAL EMERGENCY INVOLVING MY CHILD. HOWEVER, IN THE EVENT THAT I CANNOT BE REACHED, I AUTHORIZE THE CALLING OF A DOCTOR AND THE PROVIDING OF NECESSARY MEDICAL SERVICES IN THE EVENT THAT MY CHILD IS INJURED OR BECOMES ILL. I UNDERSTAND THAT ST. JOHN'S CATHOLIC CHURCH WILL NOT BE RESPONSIBLE FOR MEDICAL EXPENSES INCURED SOLELY ON THE BASIS OF THIS AUTHORIZATION. I ALSO UNDERSTAND THAT THE ADULT SUPERVISORS RESERVE THE RIGHT TO RESTRICT MY CHILD FROM ANY ACTIVITY THAT THEY DO NOT FEEL IS WITHIN THE PHYSICAL CAPABILITIES OF MY CHILD.

Name of Doctor _____ Phone number_____

Insurance Company _____ Policy Number _____

_____ ____/____/____
(Signature of Parent/Guardian) (Date)