The Diocese of St. Catharines Consent and Registration Form

St. Ann Roman Catholic Church

Please accept this registration for **YOUTH MINISTRY** to be held for **Grades 4-6** at St. Ann's Parish Hall (834 Canbor Rd.) in Fenwick on **WEDNESDAY evenings from 6:30-8:30pm. Start Date: Wednesday, September 23rd, 2026.**

I/We agree to waive, discharge and release the Parish of St. Ann and the Diocese of St. Catharines, their servants, agents, staff, affiliates and volunteers, from any and all claims or liability for damages or expenses, howsoever caused, whether by negligence or otherwise, arising directly or indirectly from this event.

I/We hereby agree to the terms of the above release. In the case of a minor child: should an emergency arise and I cannot be reached I further authorise the project supervisor to act on my behalf to make decisions pertaining to the health, welfare and safety of my child.

I/We have reviewed and agree to the expectations of participants for this event. I/We understand that any infraction of these will result in immediate dismissal at my/our expense.

_____ _____

Participant's name *Birth day (MM/DD/YY)*

MEDIA WAIVER

I, the undersigned, do hereby consent to have photographs taken of me/my child for the use in any form of media and/or publicity material produced or printed by St. Ann Parish and/or the Diocese of St. Catharines and/or other appropriate partners. The undersigned authorizes the photographer/production company to make reproductions of the photograph(s) to be used at the full discretion of the above-mentioned parties. The undersigned release and forever discharges the aforementioned parties and the photographer/ production company against all actions and claims.

CONSENT BY PARENT / GUARDIAN

I have read the above Indemnity and Media Waivers and agree to the terms.

_____ _____

Parent/Guardian signature *Date*

(Please complete both sides of this form)

YOUTH MINISTRY REGISTRATION FORM

*PLEASE **PRINT** CLEARLY*

Participant's Name: _____

First Name *Surname*

Circle: Male Female Date of Birth: _____ School:_____

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Home Address: _____

Parent's Name: _____
First Name *Surname*

Parent's contact info: _____ _____
phone *email*

Emergency contact: _____
First & Last Name Relationship phone #

MEDICAL INFORMATION

Dietary Concerns □ No □ Yes If yes,
type:_____
Diabetic □ No □Yes Medications: _____
Asthma □ No □ Yes Medications: _____
Allergies □ No □ Yes □Food: _____
□ Drugs: _____
Please check and list allergies as indicated.
□ Animals: _____
□ Insect stings/bites: _____
□ Seasonal: _____
□ Other:_____
I carry: □ Epipen □
Medications:_____
Are there any medical conditions, physical restrictions, or emergency procedures of which we should be made aware? □ No □ Yes
If yes, please explain: _____
_____
Please list other medications you are currently taking: _____
_____