

All Saints Youth Ministry**2011/2012 Registration**

Please attach a \$30 registration fee payable to All Saints Youth Ministry and mail to 9300 Stonewall Rd, Manassas, VA 20110 or submit to School Office.

Student Information

Student Name:

Address/City/Zip:

Home Phone:

Student Cell Phone:

Student Email:

Date of Birth:

Year you will graduate from H.S.:

School you attend:

Do you have any medical conditions we should know about?

Parent Information

Mom's Name:

Mom's Email Address:

Mom's Work Phone:

Mom's Cell Phone:

Dad's Name:

Dad's Email Address:

Dad's Work Phone:

Dad's Cell Phone:

Parent Volunteer Opportunities (please check the boxes)

Are you Virtus Certified Yes No

In order to make All Saints Youth Ministry program a success we need parent and adult volunteers.

Sign up and become an active member in the Youth Ministry program, there are many ways you can help out.

Food Team: Monthly donation of individual snacks or drinks for Prime Time Chaperone Monthly Outing Supervise sign in process - receive and hand out forms, answer any questions

Youth Ministry Program Support

Assist with Special Events **MEDICAL RELEASE**

I agree to indemnify the All Saints Parish, Youth Ministers, Volunteers, and the Diocese of Arlington for any costs or expenses arising out of my child's participation in the activities including the cost of any medical care given my child or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by my child in the course of his or her participation in the activity.

I further give my consent to that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Signature, parent or guardian**Date:****CATHOLIC DIOCESE OF ARLINGTON PHOTO, PRESS, AUDIO AND ELECTONIC MEDIA RELEASE**

I authorize the **Catholic Diocese of Arlington**, its parishes and/or schools to use and publish the photographs and/or motion picture of videotape for which I have posed, and/or audio recordings made of my voice. I agree that the **Catholic Diocese of Arlington**, its parishes and/or schools may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, bulletin, and Web content.

Signature, parent or guardian**Date:**

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