

Participant's Last, First Name

# Ministries Registration Form

PRINT CLEARLY

First Name

Last Name

Sex

Birth Date

Current Grade

JR.GOYA  FEES

\$25.00

SR. GOYA  FEES

\$25.00

GREEK SCHOOL  FEES

1 CHILD

\$500.00

2 CHILDREN

\$900.00

3 CHILDREN

\$1,100.00

GREEK DANCE  FEES

\$75.00

CATECHISM

ALTAR BOYS

HOPE /JOY

YOUNG ADULT MINISTRY

BYZANTINE CHOIR

YOUTH CHOIR

T-Shirt Size:

Small

Medium

Large

X-Large

1X

2X

Child (indicate size)

## Household/ Adult Primary Contact

Mother's Name: \_\_\_\_\_ Cell #: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Mother's email address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell #: \_\_\_\_\_

Father's Address (if Different): \_\_\_\_\_

Father's Email Address: \_\_\_\_\_

Email Address of Participant: \_\_\_\_\_

Cell Phone of Participant: \_\_\_\_\_

### Other designated person allowed to pick up participant:

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Cell Phone#: \_\_\_\_\_

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

**MEDICAL HISTORY FORM**  
**PRINT CLEARLY**

Emergency Contact #1 Name & Phone # \_\_\_\_\_

Emergency Contact #2 Name & Phone # \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Tel. #: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_ Tel. #: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Tel. #: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Insured ID #: \_\_\_\_\_

Does the participant take any medication on a regular basis?  Yes  No

If yes, please list medication (s), and dosage \_\_\_\_\_

Does the participant have any health problems: (For example, allergies to foods, medication, or bee stings; Diabetes, asthma, epilepsy, seizures, etc.) If yes, please explain: \_\_\_\_\_

Are there any situations or pertinent information which we should know in order to further understand the participant? Please explain \_\_\_\_\_

I GIVE PERMISSION FOR (participant's name) \_\_\_\_\_ TO BE TREATED AT THE NEAREST HOSPITAL IN CASE OF AN EMERGENCY IF I AM UNABLE TO BE CONTACTED AT THE PHONE NUMBER AND ADDRESS LISTED ABOVE. THIS PERMISSION EXTENDS TO EMERGENCY TREATMENT INCLUDING, BUT NOT LIMITED TO, SURGERY, X-RAYS AND MEDICATIONS.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

**OFFICE USE ONLY:**

**Date Received:** \_\_\_\_\_ **Check#:** \_\_\_\_\_ **Cash:** \_\_\_\_\_

**Credit Card #:** \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_

**All Paperwork completed:** \_\_\_\_\_ **Amount:** \_\_\_\_\_ **2010 OCLM** \_\_\_\_\_