Confirmation

INFORMATION & REGISTRATION

GUARDIAN ANGELS CONFIRMATION REGISTRATION---2025

Student name _____Grade entering Fall '24 _____

School 25-26 _____ Student e-mail address _____

Mom name & E-mail_____

Dad name & E-mail _____

Home Address _____ Home phone _____

Mom Cell # _____ Mom phone daytime _____

Dad Cell # _____ Dad phone daytime _____

Non-parent emergency contact & phone number_____

Please list one or two students they would like in their small group. We will do our best to accommodate requests.

Program Fee is $150. Checks or cash accepted.

PAYMENT INFORMATION (Credit Card)

Name on Card _____

Card Number _____

Expiration Date _____CVV _____

BILLING INFORMATION

Street Address _____ Zip Code _____

Email Address_____

Total Amount to Charge _____Signature _____

GUARDIAN ANGELS PERMISSION FORM AND MEDICAL RELEASE

Participant's Name:_____

Birth Date:_____ Gender:_____ Grade in 2024/25_____

Parent/Guardian's Name:_____

Home Address:_____

Home Phone:_____ Cell Phone:_____

PARTICIPANT COST: $150

I,_____ grant permission for _____
(Parent or guardian's name) (Child's name)

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify Guardian Angels and the Archdiocese of St. Paul/Minneapolis from any claims or law suits brought against Guardian Angels Archdiocese of St. Paul/Minneapolis by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by Guardian Angels and Archdiocese in defense of such a claim/law suit.

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name: _____ Phone number:_____

MEDICAL INFORMATION:

Medication my child is taking at present:_____

Known allergies: _____

Family Health Plan carrier name:_____

Family Doctor:_____ Phone number:_____

As parent or guardian, I agree to all of the above stated considerations and conditions.

_____ _____

Signature **Date**