

LIGHT OF THE WORLD CATHOLIC CHURCH

2011-2012 Registration for the EDGE

Office phone: (303) 973-3969; fax: (303) 973-2122 - www.lotw.org

Jr. High Edge Program meets from 7:00 to 8:30pm on Wednesday nights in *Archangels Hall*.

LIFE TEEN Mass is at 5:00pm on Sunday nights - All are invited to attend.

YOUTH INFORMATION:

Please Print Clearly!!!

First Name _____ Last Name _____

Nick Name/Preferred Name: _____

Address (*primary residence*) _____

City _____ State _____ Zip _____ Home Phone _____

Teen's E-Mail address: _____

School Attending: _____ Year Graduating High School 2016 (8th) or 2017 (7th)
(Please Circle)

Date of Birth: _____ (month, day, year of birth) Sex: Male or Female

Teen's other phone numbers (cell, pager) _____

PARENT INFORMATION:

Mother's Full Name _____ Work# _____

Mother's cell: _____ Mother's E-mail address: _____

Father's Full Name _____ Work# _____

Father's cell: _____ Father's E-mail address: _____

Primary Residence is with: (check one) Father Mother Both

Step Father Name: _____ Step Mother Name: _____

Home Phone of non-custodial Parent: (*If applicable*) _____

LIFE TEEN PAYMENT INFORMATION:

\$55 per child - Includes T-shirt to be picked up at the Fall Kick-Off – September 11, 2011

(Please circle size) S M L XL XXL

Can we have your permission to publish your personal information in a Teen Directory that will be used **only** by the **Adult CORE Team**? Yes No

For Office Use Only

Paid \$ _____ () check # _____ () cash Date ____/____/____ _____



LIGHT OF THE WORLD CATHOLIC PARISH

10316 W. Bowles Avenue • Littleton, Colorado 80127 • 303.973.3969

The undersigned do hereby release, forever discharge and agree to hold the **Archdiocese of Denver and Light of the World Catholic Parish** harmless from and against any and all liability, claims, demands, lawsuits, and expenses arising from personal injury, sickness, death, or property damage of any nature whatsoever which may be incurred or suffered by the undersigned and or the participant (If participant is under 18, or 18 and older) while attending the above activity. Furthermore, the undersigned hereby assume all risk of personal injury, sickness, death, damage and expense arising from the undersigned's or participant's (if participant is under 18, or 18 and older) participation in all activities, including recreation and work activities involved in the above activity. In addition, authorization and permission is hereby given to furnish all necessary transportation, food, and lodging for the undersigned or participant (if participant is under 18, or 18 and older). The undersigned further hereby agree to indemnify and hold the Archdiocese of Denver, the above named Parish, and their respective members, directors, employees, and agents (collectively, the 'Indemnities'), harmless from and against any and all claims, demands, actions, lawsuits and liabilities, including attorney's fee and expenses sustained by the Indemnities as the result of the negligent, willful, or intentional acts of the undersigned and/or participant (if participant is under 18, or 18 and older).

If participant is under 18 years of age: We (I) are the parent(s) or legal guardian(s) of the participant, and hereby grant permission for _____ to participate fully in the above activity and all of its undertakings, and hereby give our permission to take said participant to doctor or hospital and hereby authorize medical treatment, including but not limited to emergency surgery; and, we fully and completely assume responsibility for all medical bills. Furthermore, should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, I (we) assume all responsibility and transportation costs.

This form MUST be signed by ALL participants

Participant's Signature _____ Date _____

Parent / Legal Guardian Signature _____ Date _____

Printed Name _____ Phone # _____

Emergency Contact _____ Phone # _____

***Please list all medical information in the space provided on the reverse of this document.**





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Participant _____

Doctor's Name _____ Phone _____

Insurance Company _____ Policy # _____

Preferred Hospital provider if applicable _____

Medical Concerns: Please list all information pertaining to allergies, diet, special medications, health conditions or any other information necessary in an emergency situation. Explain fully.

Allergies, _____

Prescription medications (please include name of prescription, dosage and times)

Permission to give over the counter medications

We (I) are the parent(s) or legal guardian(s) of the participant, and hereby grant permission for _____ to be given common over the counter medications as necessary for non-emergency treatment of minor ailments. **Please list any exceptions**

Parent / Legal Guardian Signature _____ Date _____

