

**LIGHT OF CHRIST LUTHERAN CHURCH CONFIRMATION MINISTRY**  
**2009-2010 PATH Student Registration**

I want to attend PATH on Wednesday \_\_5:45 – 7:15pm \_\_7:00 – 8:30pm (choose one)

Student's Name \_\_\_\_\_ (circle one )M/F Phone\_\_\_\_\_

Prefers to be Called \_\_\_\_\_ Student E-mail Address \_\_\_\_\_

Birthday \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Baptized? \_\_\_Yes \_\_\_No Date\_\_\_/\_\_\_/\_\_\_ Place\_\_\_\_\_

Received Pre-Communion Instruction? \_\_\_Yes \_\_\_No

Father's Name: \_\_\_\_\_ Stepfather's Name \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Stepmother's Name \_\_\_\_\_

Guardian's Name: \_\_\_\_\_

Additional Addresses- for mailings to above adults:

\_\_\_\_\_

Whom does student live with? \_\_\_\_\_

Brothers/Sisters: Name \_\_\_\_\_ Age/Grade \_\_\_\_\_

Name \_\_\_\_\_ Age/Grade \_\_\_\_\_

Name \_\_\_\_\_ Age/Grade \_\_\_\_\_

Name \_\_\_\_\_ Age/Grade \_\_\_\_\_

Names and phone numbers of people who can pick student up from Confirmation

1. \_\_\_\_\_

2. \_\_\_\_\_

Name/s of other students that you are friends with at LOC \_\_\_\_\_

\_\_\_\_\_

Are there any developmental issues that we should know about that will help us in teaching and relating to your student? If so, briefly describe the situation or indicate that you would like to speak with a staff member. \_\_\_\_\_

\_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Name \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Best Time to Reach You \_\_\_\_\_

Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Hobbies, interests, special skills or talents (music/drama gifts, cooking, carpentry, mechanics, etc.)  
\_\_\_\_\_

Name \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Best Time to Reach You \_\_\_\_\_

Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Hobbies, interests, special skills or talents (music/drama gifts, cooking, carpentry, mechanics, etc.)  
\_\_\_\_\_

**Please use the initials of each parent/guardian to mark areas of interest or to indicate willingness to volunteer:**

\_\_\_\_\_ Administration (tracking, filing, copying, etc.)

\_\_\_\_\_ Small Group Leader (Wednesday evening)

\_\_\_\_\_ Help with service projects

\_\_\_\_\_ Chaperone PATH RETREAT/PATH BASH

\_\_\_\_\_ Set-up/Clean-up events

\_\_\_\_\_ Help with fellowship events

\_\_\_\_\_ Provide transportation

\_\_\_\_\_ Organize fundraising

\_\_\_\_\_ Provide snacks/food

**Registration fee if paid on or before 8/16/09 - \$45.00**

**Registration fee if paid 8/17/09 or later - \$50.00**

(Please make checks payable to Light of Christ Lutheran Church)

**Permission Slip/Medical form for the Path and LOC Student Ministry  
Events  
2009/2010  
Light of Christ Lutheran Church**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City and Zip: \_\_\_\_\_

Grade: \_\_\_\_\_

Confirmation Class of (circle one): 2010/2011/2012

I give my permission for my above named child to join the Path/Confirmation Class of Light of Christ Lutheran Church for events taking place at Light of Christ Church or any other locations. I understand, when traveling is involved, the vehicles will be driven by adult chaperones.

I hereby release Light of Christ Lutheran Church, its staff, lay leaders, volunteers, chaperones and sponsors from responsibility and liability for any injury or illness that my child may sustain during any activity. In the event of an emergency, I hereby authorize an adult leader of that activity, as agent for me, to consent to any x-ray examination; medical, dental or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible.

Signature of parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency phone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

If I cannot be reached please contact: Name \_\_\_\_\_

Phone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

**Medical Information**

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical handicaps or limitations: \_\_\_\_\_

Medical insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_

Member's name: \_\_\_\_\_

Light of Christ Student Ministries  
Medication Administration Form

Student's name \_\_\_\_\_

Phone \_\_\_\_\_

Name of Medication	Dose	Time of day to be given	With Food? Yes or No	Comments

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date