**SAINT BRIGID ROMAN CATHOLIC CHURCH**
**LIFE TEEN REGISTRATION FORM 2025-26**

3400 OLD ALABAMA ROAD, JOHNS CREEK, GA 30022
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LIFE TEEN
Leading Teens Closer to Christ

**$140 Registration Fee**

**FAMILY NAME**: _____ **ENVELOPE #**: _____

**Emergency Phone Number**:_____Relationship to student:_____

Mailing Address:_____
Street City Zip Code

Phone: _____ Email Address: _____

**REQUIRED– PLEASE UPDATE**

Father's Full Name: _____Father's Cell: _____

Mother's Full Name: _____Mother's Cell: _____

**STUDENT INFORMATION:**

_____
Last First Middle Goes by

Student email: _____Student Cell: _____

Date of Birth: _____ Male_____ Female_____

**2025/26 Grade _____School Student Attends in 2025-26** _____

Health Concerns/Allergies/Special Needs**:** _____

Sacraments Received (Circle if YES): Baptism First Communion Reconciliation Confirmation

**POLICY OF THE ARCHDIOCESE OF ATLANTA CONCERNING THE PROTECTION OF CHILDREN (PLEASE READ AND INITIAL):**

_____I hereby grant my approval for my child to attend the Archdiocesan training, which will be presented on Sunday, Oct 19, 2025 during our Life Night in the Life Teen Room (Room 133). **–OR-**

_____I decline to grant approval for my child to attend the archdiocesan training. Information about this program available at: http://www.archatl.com/ministries-services/safe-environment/grades-k-12/

**PARENT/GUARDIAN CONSENT:**

- I give permission for my child to attend all Sunday and Wednesday Life Teen activities, including offsite activities promoted by Life Teen.
- Saint Brigid staff is not responsible for teens that choose to leave an event without permission.
- I understand that promotional pictures (individual or group) will be taken at Life Teen events. I give permission for my teen's pictures to be used for promotional materials (permission slips, newsletter, webpage, calendars, parish bulletin, social media, etc.) highlighting the event. I release and relieve the parish and/or school, and the Archdiocese of Atlanta, from any responsibility or liability for any claims arising from the publication or reproduction of any photographs or interview in any news or other media. I waive any and all right to inspect or approve the finished images, video, or printed matter that may be used in conjunction with any image or video, or to approve the eventual use for which it may be applied.
- I give permission for the Saint Brigid Youth Ministry staff and adult volunteers to contact my teen via: e-mail, text, social media and/or parish/school-approved online/virtual platforms when it pertains to youth ministry. I understand I can request the same communications provided to my child, and that it does not have to be via the same technology.

_____
**Parent /Guardian Signature**

**(BOTH SIDES NEED TO BE COMPLETE AND SIGNED)**

**CATHOLIC ARCHDIOCESE OF ATLANTA**
**Saint Brigid Life Teen**
**2025-2026 Annual Medical Release**

**Name of Student**:_____ **Date of Birth**:_____

**Address:** _____

_____**Home phone #:** _____

**Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor and hospital. If you are unable to reach me, contact:

Emergency contact _____ Phone # _____

Relation to participant _____

**If you are unable to reach parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgment in treating participant.**

Medical / Hospital Insurance Carrier _____

Name of Policy Holder _____ Relation to participant _____

Policy Number _____ Group Number _____

Signature of Parent / Guardian _____ Date _____

**Father/Guardian's full name:** _____

**Phone #:**_____ **Cell #** _____**Work Phone #:** _____

**Home address:**_____

**Place of business/address:**_____

**Mother/Guardian's full name:**_____

**Phone #:**_____ **Cell #** _____**Work Phone #:** _____

**Home address:**_____

**Place of business/address:**_____

Medications: My child is taking the following medication(s):
Description _____ Dosage _____

Description _____ Dosage _____

(EITHER A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRESCRIPTION / NOTE SHOULD BE ATTACHED TO THIS FORM.)

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

Drug allergies _____

Other allergies / reactions (food, plants, insects, etc.) _____

List any other health problems / limitations that we need to be aware of _____

**Signature of Parent / Guardian** _____ **Date** _____

**(This Medical Release is good for the period of one year; beginning May 1, 2025 and ending May 1, 2026)**