Totus Tuus is a diocesan Catholic youth program dedicated to helping young people develop a greater understanding of their faith so that they can live it in today's world. This is done in such a way that it is fun for both the college age teachers and youth alike.
Registration is required for both programs. Please return forms to Seven Dolors Parish Office.

Grade School Program

The curriculum for the Grade School Program this year will focus on the Mystery of Salvation and the Luminous Mysteries.

This is for students who have completed Grade 1-6 during the 2017/18 school year
Monday, July 9- Friday, July 13
Time: 9:00 a.m. - 3:00 p.m. at Seven Dolors
Fee: $35/child.
Bring a sack lunch and a water bottle each day labeled with your name.
There will be refrigeration available.

Junior and Senior High School Program

The Junior High and Senior High School Program include instruction, small group discussions, quiet meditation, prayer and fellowship. Junior and Senior High Students are separated during instruction and small group sessions.

This is for students who have completed Grade 7-12 during the 2017/18 school year.
Sunday, July 8-Thursday, July 12
Time: 7:30 p.m. - 9:45 p.m. at Seven Dolors
There is NO FEE for the Jr/Sr High Program

**7 thru 12 Grade Students who would like to volunteer during the Grade School program are only eligible if they are registered for the evening Totus Tuus program and fill out the youth volunteer form.

Please contact Deb Price or Lori Harlan.**

Registration Deadline June 27, 2018

Registration Forms and Diocesan Forms can be found on line at:

Sevendolors.com

For any questions please contact

Lori Harlan
785-532-8072
lharlan@gmail.com

Deb Price
539-5000 x118
reoffice@sevendolors.com

TOTUS TUUS
Registration Form

Must be received by Wednesday, June 27, 2017 in the Parish Office

Parish you are registered: St. Isidore's St. Thomas More Seven Dolors Other: _____________

	FATHER		**MOTHER**	
Name	First	Last	First	Last
Phone	Cell	Work	Cell	Work
Email				

Emergency Contact ______________________________

Relationship to Child ____________________ **Phone** ____________________

Student Name	Age	Grade Completed	Allergies* Y/N

*Allergies will be listed on FORM B

☐ Permission is hereby granted to Seven Dolors Parish for use of photographs of and/or quotations from my child(ren) to assist in community awareness, educational efforts, and related public relations efforts that may include brochures, posters, website, and printed media.

Parent Signature ____________________ Date ____________

Please notify the church of date(s) and time(s) your child will not be present. If we are expecting them and they are not present at roll call, we will notify you.

____

____

Be sure to include the following:

□ Registration fee of $35/child (No fee for 7 – 12 grade)
 Checks payable to Seven Dolors

□ I am donating $5-$10 to help provide snacks for the students

□ Registration Form Completed

□ Forms B and HIPPA

Official legal form for the Diocese of Salina **FORM B**

Date ____________________

MEDICAL INFORMATION

This form should be completed for any person (under 19 years of age) in parish religious education, Catholic schools, and youth programs and should be completed on an annual basis at the beginning of the program.

Diocese _____Salina_______________ Parish ______________________ School ______N/A____________

Participant's Name ____

Date of Birth ____________________ Place of Birth ____

PLEASE PRINT OR TYPE

Participant's Regular Physician:

Name (first, middle, last): ___________________________ Phone (including area code): ___________________

Medical Conditions:

Please list any medical conditions of the participant (asthma, diabetes, epilepsy, etc): ________________________

____

List below any physical condition the sponsors, doctors, nurses, or other medical personnel should be aware of:

Insect stings: ____

Fainting spells: ____

Allergies: ____

Ear infections: ____

Seizures: ____

Heart condition: ____

Headaches: ____

OTHER: ____

List any allergies or allergic reactions to medications of the participant: ___________________________________

____

Other pertinent medical information: ____

____

Date of Participant's last immunizations: MMR______________TB ______________ TETANUS ___________

Special dietary needs/restrictions: ____

(over)

Medications:

Prescribed medication now being taken:

Type: __________________________ Dosage: __________________________ How often: ______________________

Activities individual should not participate in: ____

____

Medical Insurance Information:

Company: ____

Plan Number: __________________________________ Employee Identification #: ___________________________

Emergency Contacts:

Parent or Guardian

Name (first, middle, last): ____

Daytime Phone (including area code): ____________________ Evening Phone (including area code): ____________

Other Contact

Name (first, middle, last): ______________________________ Phone (including area code): ___________________

Relationship (friend, neighbor, coworker, etc): ____

ROMAN CATHOLIC DIOCESE OF SALINA
AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME	BIRTH DATE

CHECK ONE:
BY SIGNING BELOW, I HEREBY AUTHORIZE ANY HEALTH CARE PROVIDER THAT HAS PROVIDED TREATMENT TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO:

Catholic Chancery Office
103 N. 9th Street, P.O. Box 980
Salina, Kansas 67402-0980

For Treatment date(s): ____
Specify date(s) - this line MUST BE completed

For the following purpose(s): _________At the request of the patient______________________________

If the request is initiated by the patient (Or patient representative), insert "at the request of patient;" otherwise, describe purpose of use or disclosure. If the purpose relates to marketing, indicate whether Provider will receive remuneration.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED (Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provides unless records were prepared on behalf of Provider	
G	Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected)
G	Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.
G	Other ____

_______________ ____
Date *Signature of Authorized Agent/Representative (Parent)*

____________________________________ ____________________________________
Printed Name of Authorized Agent/Representative (Parent) *Relationship of Authorized Agent/Representative*

____________________________________ ____________________________________
Address of Authorized Agent/Representative *Telephone # of Authorized Agent/Representative*

____________________________________ ____________________________________
Date *Signature of Witness*

ORIGINAL - Privacy Officer COPY - Patient Medical Record
For Office Use Only: For each disclosure made pursuant to this authorization, list the name of the person/entity to whom the disclosure was made; a description of the disclosed; the date on which the disclosure was made; any fees charged in connection with the disclosure; and the name of the person making the disclosure.