

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





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
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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.

<small>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)</small>	
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.