SAINT BRIGID Youth YOU ARE LOVED JOHNS CREEK • GEORGIA

SAINT BRIGID ROMAN CATHOLIC CHURCH
3400 OLD ALABAMA ROAD, JOHNS CREEK, GA 30022
TRICIA BORAH
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LTE SPECIAL NEEDS GROUP REGISTRATION FORM 2024-25

Please check one:

___ My child will be eating the dinner provided – **$150 registration fee**

___ My child will be bringing his or her own dinner - **$100 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:_____

Date of Birth: _____ Male____ Female ____

2020/21 Grade Level: _____ School Student Attends in 2020/21:_____

Sacraments Received: *Circle:*	Baptism	First Communion	Reconciliation	Confirmation
	Yes No	Yes No	Yes No	Yes No

Child's primary diagnosis and/or health concerns we should be aware of: _____

_____

_____

CARE NEEDS:

VISION: ___Typical ___Impaired ___Blind
HEARING: ___Typical ___Impaired ___Deaf ___Hearing Aid
MOTOR: ___Head control ___Rolls over ___Sits ___Crawls ___Walks
USES: ___Walker ___Crutches ___Braces ___Wheelchair

Please describe any special positioning or other needs your child may have: _____

_____

CAN COMMUNICATE WITH OTHERS USING:
Speech: ___Words ___Phrases ___Sentences ___Babbles ___Gestures ___Sign Language
___Other (describe): _____
Language spoken at home: _____

CAN UNDERSTAND WHAT OTHERS SAY: ___All the time ___Most of the time ___Some of the time
___Recognizes voices of family members.

TOILETING SKILLS:
___Toilets independently ___Diapers: ___Cloth ___Disposable
___Currently being potty trained ___Potty trained, needs assistance
Frequency/Schedule: _____

How does your child indicate a need to use the toilet? _____

EATING HABITS:
Feeds self by using: ___spoon ___ fork ___hands ____Requires feeding ___Bottle fed
Drinks from cup: ___with assistance ___by self

Special Diet: _____

If your child is difficult to feed, please describe any special assistance or adaptive utensils required for eating: _____

ALLERGIES: (Drugs, Food, Other) _____

BEHAVIOR: (check all that apply)

___Shy
___Plays alone
___Adapts to new situations well
___Adapts to new situations with difficulty
___Responds to correction well
___Responds to correction with difficulty
___Outgoing
___Plays in groups
___Is sometimes destructive
___Sometimes threatens others
___Sometimes hits, bites, or hurts self/others
___Sometimes attempts to run away
___Hyperactive and/or ADD

My child responds to separation from his/her parents by: _____

_____

My child is best comforted by: _____

_____

My child lets someone know what he/she wants or needs by: _____

_____

My child becomes upset when/or does not enjoy: _____

_____

How can we redirect inappropriate behavior?_____

_____

These are a few of my child's favorite things: _____

_____

_____

_____

_____

You didn't ask, but I want you to know this, too: _____

_____

_____

_____

LTE: Special Needs Youth Group

Catholic Archdiocese of Atlanta

Saint Brigid Catholic Church

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 Phone#** _____

Home address:_____

Place of business/address:_____

_____ **Phone #:** _____

Mother/Guardian's full name:_____

Phone #:_____**Cell Home #** _____

Home address:_____

Place of business/address:_____

_____ **Phone #:**_____

(Both sides need to be complete and signed)

Name of Participant _____

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 _____

_____

This Medical Release is good for the period of one year; beginning May 1, 2024 and ending May 1, 2025.

Photo Release

- I understand that promotional pictures (individual or group) will be taken at Life Teen/Edge Special Needs 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.

Signature of Parent / Guardian _____ Date _____