



14951 North Haggerty Road  
Plymouth, MI 48170-2756  
(734) 420-0288  
[www.stkenneth.org](http://www.stkenneth.org)

April 22, 2019

Dear future 7th grade students and Parents,

Pre-Confirmation preparation is offered to all Saint Kenneth seventh grade students. Classes will begin in September and run approximately twice each month on **Wednesday evenings, 6:00-8 p.m.**, through March. This program is to better prepare you for Confirmation in eighth grade. The program we will be using is called Decision Point. The program has a free app if you'd like to look at the material prior to class. Unlike 6th grade LOGOS, Pre-Confirmation does not have a meal but, there will be a break and a snack will be provided. Each student will receive a workbook that will stay at Saint Kenneth's until the last class. The program is a combination of workbook activities, videos, journaling, and table discussions. This is where parents come in; we will need at least 10 table parents to be at every session to help facilitate the discussions and keep students on task.

**Please make note, 7th grade Pre-Confirmation is ONLY offered on Wednesdays (about 2 times a month).**

The Pre-Confirmation registration form follows this letter. Please have a discussion with your student about the importance of these classes to better prepare for the final sacrament of initiation in the Winter of 2021. If you have questions, please feel free to call the parish office or e-mail me at [joanna@stkenneth.org](mailto:joanna@stkenneth.org). I look forward to continuing your students faith formation here at Saint Kenneth.

Sincerely,

*Joanna Vaghy*

Logos and Youth Ministry  
Saint Kenneth Catholic Community  
734-927-1253

# Saint Kenneth Catholic Community

## 7th Grade Pre-Confirmation

### 2019-2020 Registration

Date: \_\_\_\_\_

Family Name: \_\_\_\_\_

E-Mail \_\_\_\_\_

\*E-mail will be added to our flocknote email system, our main form of communication\*

Address: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

City/Zip: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Single Parent Home: Yes No

Mom Cell Phone: \_\_\_\_\_ Child Resides With: \_\_\_\_\_

Dad Cell Phone: \_\_\_\_\_

**Wednesdays 6:00-8:00pm**

	<u>Student's Name</u>	<u>7th grade</u>	<u>School Name</u>
M F	_____	_____	_____
	Special Needs: medical, learning disabilities, allergies: _____		
M F	_____	_____	_____
	Special Needs: medical, learning disabilities, allergies: _____		
M F	_____	_____	_____
	Special Needs: medical, learning disabilities, allergies: _____		

**Parent Commitment (please indicate first and second choice)**

\_\_\_ Table Parent      \_\_\_ Snack Help

**Parent Volunteer Name:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(other than parent)

*During the course of the year, we may take pictures that involve your child. May we put these pictures in the church bulletin and/or on our website? No names will be listed.*

\_\_\_ Yes    \_\_\_ No    **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Registration Fee: \$80.00 per child**  
Checks payable to: **Saint Kenneth Faith Formation**  
Amount Paid: \_\_\_\_\_ Check here to bill later:

OFFICE USE ONLY:

DATE:

Amount paid

Check/cash

# MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reason for which release is intended: \_\_\_\_\_

Address of Minor: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Phone(s): \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_

List allergies, medication, contract, or other pertinent comments:

---

---

Health Insurance Data:

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

(Parent or Guardian)