St. Gerald Parish

Faith Formation Registration Information

21300 Farmington Road
Farmington, MI 48336

(248) 477-7470 ext. 201
FaithFormation.sgp@gmail.com

MISSION STATEMENT

St. Gerald Roman Catholic Church is a welcoming, inclusive parish striving to be a reflection of Christ. Guided by the Holy Spirit, we are dedicated to strengthening our faith through reverent and uplifting worship, serving those in need, and living the fullness of the Gospel with all God's people.

2026 – 2027 REGISTRATION FORM
FAITH FORMATION FOR GRADES 1 – 8 AT ST. GERALD PARISH

STUDENTS ENROLLING IN GRADES 1 – 8

Student's Full Name	Birth Date	Faith Formation Grade*	School	School Grade
1.				
2.				
3.				
4.				

This is the grade level student is in during the 2026-2027 school year.

CLASS DAYS AND TIMES

ELEMENTARY GRADE 1 THROUGH GRADE 6
Classes Begin September 14, 2026
Every Monday from 5:30 - 6:45 pm

CONFIRMATION PREPARATION GRADES 7 & UP
Every other Monday evening from 5:30 - 6:45pm
Beginning with Parent Orientation on September 14, 2026

PLEASE NOTE FOR SACRAMENTAL PREPARATION,
2 years of formation is required, with absences over 2-3 sessions made up.

CHILD(REN)'S WEEKLY ADDRESS AND TELEPHONE NUMBER:

Address: ____

City: ______________________________ Zip: ________________

Home Phone ____________________ Cell Phone ______________________

Preferred Email (s) ____

________________________________ ________________________________

FAMILY INFORMATION

MOTHER: Name: ______________________ Maiden Name: ______________________

Cell Phone: ______________________ Work Phone: ______________________

FATHER: Name: ______________________

Cell Phone: ______________________ Work Phone: ______________________

REGISTRATION AND FEE DUE NO LATER THAN AUGUST 15TH

REGISTRATION FEES FOR GRADES 1 – 8:

One Child $75.00

Two Children $130.00

Three or More Children $170.00

OPTIONAL:
An additional donation of $20.00 to offset costs of Children's Liturgy and Sacramental Preparation may be made

Total amount due: $ __________________ Amount Paid $ __________________ ☐ Check # ______________

☐ Cash Enclosed

Please make checks available to St. Gerald Church.

If you are in need of financial assistance or would like to arrange a payment schedule, please call Emily Long at 248-476-7677 ext. 201 or email at faithformation.sgp@gmail.com

Are you registered as a St. Gerald parishioner? ☐ YES ☐ NO

Previous Parish _______________________________________ City ________________________________

Are there special family situations or dietary/medical concerns that you would like us to be aware of?

____

____

Do you give permission for photos of your child to appear in the church bulletin? ☐ YES ☐ NO

Do you give permission for photos of your child to appear on the church website? ☐ YES ☐ NO

In order to maintain a strong Faith Formation program for our children please indicate if you are interested in receiving more information regarding one of the following areas in which to volunteer. This would be a good opportunity to receive training if you are interested in serving in one of the ministries next year.

☐ Catechist/Teacher

☐ Substitute Catechist

☐ Children's Liturgy of the Word Facilitator – 20 minutes during the 10:15am Mass

For any questions, please feel free to contact the office at:

248- 476-7677 ext. 201, or faithformation.sgp@gmail.com

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): ___________________________________ Alt. _____________________________________

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. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: ___________________________________ Signed: ____
(Parent or Guardian)