ST. MATTHEW CYO

DUES $25.00
TO: SMA CYO*

MEMBERSHIP PROFILE

July 1, 2026 to June 30, 2027

Name:	
Home Address:	
City, State, Zip:	**T-Shirt Size:**
Date of Birth:	**Age:**
[ ] Male [ ] Female	**Teen Cell:**
School:	**Grade:**
Teen Email:	
Mother's Name:	**Mother's Cell:**
Mother's Email:	
Father's Name:	**Father's Cell:**
Father's Email:	
Residing Church Parish:	

St. Matthew the Apostle - C...
@stmatthewcyo

venmo

_____ _____

SIGNATURE OF MEMBER DATE

*Dues can be paid by cash, check, CYO account or Venmo. Venmo QR:

PLEASE DO NOT WRITE BELOW THIS LINE

****

DATE:_____ [ ] VENMO [ ] CASH [ ] ACCOUNT [ ] CHECK# _____

St. Matthew the Apostle CYO

ARCHDIOCESE OF NEW ORLEANS
MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.

2. **Sections I, II and V are mandatory.** Sections III and IV are optional, providing you with treatment options in non-emergency situations.

PERSONAL INFORMATION

Participant's name:

Section I. MEDICAL MATTERS (MANDATORY)

As the parent/legal guardian of the above named child, who is currently associated with St. Matthew the Apostle Parish, I hereby authorize Fr. Lee Poche, or his assistants to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from **July 1, 2025 through June 30, 2026**. I hereby warrant that, to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Signature: _____ **Date:** _____

Section II. EMERGENCY MEDICAL TREATMENT (MANDATORY)

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the numbers listed herein, contact:

#1 Name and relationship:	**#2 Name and relationship:**
#1 Phone:	**#2 Phone:**
Family doctor:	**Phone:**
Health Plan Carrier:	**Policy #:**

Signature: _____ **Date:** _____

***PLEASE ATTACH COPY OF MEDICAL INSURANCE CARD
OR SCAN/SEND A COPY TO smadre@arch-no.org***

SECTION III: OTHER MEDICAL TREATMENT

In the event it comes to the attention of the parish, its officers, directors and agents, chaperones or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature: _____ **Date:** _____

SECTION IV: MEDICATIONS

(Sign only those that are applicable)

- My child is taking medications at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency, are as follows:

Signature: _____ **Date:** _____

- I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child if deemed appropriate.

Signature: _____ **Date:** _____

- NO MEDICATION of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ **Date:** _____

SECTION V: MEDICAL INFORMATION (MANDATORY)

The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

_____

Immunizations: Date of last tetanus/diphtheria immunization: _____ **(YEAR)**

Does child have a medically prescribed diet? _____

Any physical limitations? _____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? If so, date and disease or condition: _____

Any other medical conditions/notes regarding my child: _____

_____

_____

St. Matthew the Apostle Release Form

I, _____, the undersigned parent/guardian of _____

a dues paid member of St. Matthew the Apostle Catholic Youth Organization (SMA CYO), hereby grant permission to SMA CYO and/or the Archdiocese of New Orleans to publish and/or print my/our child's name and/or likeness on the SMA CYO website, Facebook, on the internet and/or world wide web.

I hereby further release, indemnify and hold harmless SMA CYO, the Roman Catholic Church of the Archdiocese of New Orleans, their directors, officers, agents, pastor, employees and insurers from any and all claims and/or damages on behalf of myself/ourselves and/or our child arising from the publication of my/our child's names, photograph, or likeness on videotape and/or film on SMA CYO website, Facebook, on the internet or the world wide web.

This agreement shall remain in force and effect at all times during my child's membership at St. Matthew the Apostle Catholic Youth Organization.

Member's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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News, Updates, Event Info & More is sent out through GroupMe!
Use the QR code to join (Groups are the same as 25-26).

Parent GroupMe 26-27:

SMA CYO Parents!

Scan the QR code to join the group

groupme

Teen GroupMe 26-27:

SMA CYO!

Scan the QR code to join the group

groupme

@smacyo504

stmatthewcyo.com