faith IN THE FUTURE™

Sustainable Catholic Education for All Who Desire It™

Student Name: _____

Grade: _____

Address _____

City, State, Zip _____

Parent/Guardian Home Phone Number _____

Parent/Guardian Cell Phone Number _____

School(s) where you wish to Shadow: Archbishop Ryan High School

Do you have a friend in the school that you would like to shadow?
If so, please write your friend's name: _____

Do you have any medical conditions? Please list._____

_____

Parent/Guardian Signature: _____

Date: _____

You will be contacted to set up the date for the Shadow Program visit.

Thank you.