

2019 VBS REGISTRATION FORM-PLEASE RETURN BY JULY 1, 2019

APOSTLE PRESBYTERIAN CHURCH

FIRST UNITED METHODIST CHURCH

MOUNT HOPE LUTHERAN CHURCH

Child's Name _____

Child's Age _____ Date of Birth _____ Last School Grade Completed _____

Name of Parent/Guardian

Street Address _____

City _____ State _____ Zip _____

Phone/Cell Phone Number

In case of emergency, contact _____

Relationship to child _____

Allergies or other medical conditions/any special needs _____

For the safety of the children, please indicate who will be picking up your child each day (relationship to child)

I acknowledge that I am the parent or legal guardian of the child and I release Apostle Presbyterian , First United Methodist , Mount Hope Lutheran, and its agents, employees, representatives and volunteer workers from any and all liability if my child is injured July 16-20, 2018 during any VBS activity. I give permission to photograph/video my child during VBS and to use such photographs/videos in all forms of media, including crafts, class pictures, videos/slideshows, websites, newsletters, and displays.

Parent/Guardian signature _____ Date _____

PLEASE COMPLETE EMERGENCY MEDICAL FORM.

2019 Vacation Bible School
Medical/Emergency Information

Person to contact in case of emergency:

Name _____ Relationship to child _____

Daytime Phone _____ Evening Phone _____ Other _____

Address _____

Family Doctor Name and Phone _____

Alternate contact:

Emergency Contact _____ Phone _____

Relationship to child _____

Insurance Information:

Child is covered by a medical insurance policy: ___Yes ___No

Insurance Company _____ Name of Policy Holder _____

Group Policy Number _____ Authorization Phone Number _____

I, the undersigned, hereby give permission for my son/daughter to participate in Vacation Bible School events and activities. I authorize any adult representative of Apostle Presbyterian, First United Methodist or Mount Hope Lutheran who is acting in a leadership role to consent to and authorize the administration and performance of all treatments that may be considered advisable or necessary in the judgment of attending physicians, in the event that the above named participant should be admitted to any hospital, or be in need of any medical treatment. I take full responsibility for all charges and fees related to treatment.

I understand that the care and safety of the participant will be primary in all planned activity and that all attempts will be made to contact parents/guardians prior to treatment if an emergency or accident should happen.

Parent/Guardian signature _____ Date _____