VBS Child Registration Form

Child's Name:_____ __ **Male / Female** **DOB:** _____

Child's Grade (completed)_____

Is there a friend your child would like to be grouped with:_____

Parents Names:_____

Parent's Email: (please Print Clearly)_____

Address:_____ **City:**_____ **Zip:**_____

Phone:_____ _____**Cell:**_____

Emergency Contact:_____**Phone:**_____

Do you attend a church regularly? Y / N__If so, where?_____

Please list any allergies or medical conditions we should be aware of about your child

_____

Staff of Hope Church may want to interview, photograph or videotape your child/ren for use in publications, TV reports, church web pages and public presentations. Please INITIAL one below.

_____ **I give permission for my child/ren to be photographed or interviewed and to have my child's name used.**

_____ **I give permission for my child/ren to be photographed or interviewed, but DO NOT want my child's name used.**

_____ **I DO NOT give permission for my child/ren to be photographed or interviewed and DO NOT want my child's name used.**

I/We understand and accept that Hope's leadership has reasonable goals and expectations for those taking part in its programs. Should my child fail to participate within the rules, I/we understand that I/we will be contacted and will take responsibility to come and get my child. I/We agree to support Hope's leadership in its discipline procedures. I/we will not hold Hope church or the supervising adults responsible for any injuries or property damage sustained on this trip. I/We agree that I/we will not at any time in the future prosecute any action against Hope Church in connection to the actions that are hereby released and waived by me.

Parent's Signature:_____ **Date:**_____

If you have any questions, please contact Katie Bliss at katie.bliss@hopechurchoakdale.com **or 651.738.9652.**

HOPE CHURCH
PERMISSION TO ADMINISTER MEDICATIONS

In the event that your child requires medications administered daily or in the event of an allergic reaction (rescue inhaler, epi pen, etc.), please fill out below information and send medication with your child in a labeled quart size Ziploc bag to be surrendered at the registration table at the beginning of the event.

Medication Name _____

Dosage _____

Time/s to administer meds _____

Date/s to administer meds _____

Medication Name _____

Dosage _____

Time/s to administer meds _____

Date/s to administer meds _____

Medication Name _____

Dosage _____

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Medication Name _____

Dosage _____

Time/s to administer meds _____

Date/s to administer meds _____

I give permission for Hope staff to administer the above medications for my child.

Parent signature: _____ Date _____