ST. MICHAEL'S
CATHOLIC CHURCH
2017 VACATION BIBLE SCHOOL
Date: July 24 – 28
Time: 6:00 – 8:30 p.m.

REGISTRATION FORM
FOR CHILDREN AGES 4 – 10 YEARS

Parent/Guardian Name:_____

Home Phone_____ **Cell Phone:**_____

Address:_____

City, State, ZIP_____

Person responsible for drop-off or pick-up (if different from parent):

Name(s):_____ **Phone:**_____

Child's Name_____**Age**_____ **Allergies Y or N**

Child's Name_____**Age**_____ **Allergies Y or N**

Child's Name_____**Age**_____ **Allergies Y or N**

Child's Name_____**Age**_____ **Allergies Y or N**

~ Please specify the type of allergy on the medical release form ~

My child(ren) will attend: _____all days or only: M T W TH F

Photography Release

As legal guardian, I give permission for _____to participate in St. Michael's Vacation Bible School. I understand that photography and/or video of participants may be procured during this programming. I consent to the use of images or likenesses of the aforementioned person(s), for promotional purposes, by St. Michael's Parish, Coopersville, Michigan.

Signature_____ **Date** _____

******COST: Free Will Donation******
Medical Treatment Release Form on Page 2

St. Michael's Parish
17150 -88th Avenue
Coopersville, Michigan 49404

Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian, I do hereby authorize first aid/medical treatment of my child or children in the event of an emergency which may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible.

Name of child(ren)_____

Reason for which release is intended: First Aid/Medical Treatment

Address of child(ren)_____

Emergency Phone_____Cell_____

Family Physician_____Phone_____

Address_____City_____

List child's name and allergies (including food), medication or other pertinent comments:

_____
_____
_____
_____

Health Insurance Data:

Company_____Policy_____

Group_____Contract_____

This release form is complete and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstance in my absence.

I certify that I am the (check one) _____custodial parent_____ legal guardian of the minor child(ren) named above, and agree to the above terms for myself and for my minor child.

Date_____ Relationship to Child(ren) _____Signature_____