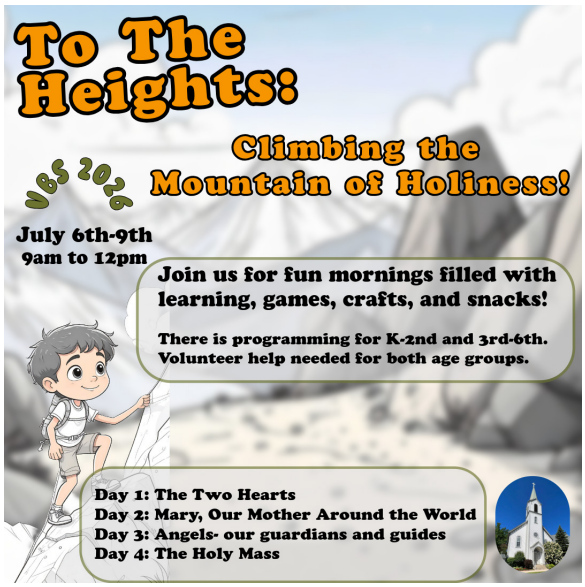

K-6th Grade

When: July 6-9

Time: 9am-12pm

Where: Holy Childhood of Jesus

Suggested donation $20 per child or $30 per family

No one will be turned away due to lack of funds.

Registration Form **Please fill out one form per child.**

Child's name: _____ Child's gender: _____

Child's age: _____ Date of birth: _____ Last school grade completed: _____

Name of parent(s): _____

Street address: _____

City: _____ State: _____ Zip: _____

Home telephone: (_____) _____

Parent/caregiver's cell phone: (_____)_____

E-mail address: _____

Home church: _____

Allergies or other medical conditions: _____

In case of emergency, contact: _____

Phone: (_____) _____

Relationship to child: _____

As parent/guardian of the youth named above, I understand that promotional pictures and videos (individual and group) may be taken during this event. I give permission for my child's picture, name, age, comments, parish/ school and city, to be used for news and promotional materials (including, but not limited to, print, web pages, online social media, calendars, power point, audio, video, broadcast, etc.) for the Diocese of Gaylord and HCJC.
In consideration of my child being allowed to participate in HCJC VBS, I agree to indemnify and hold harmless Holy Childhood of Jesus any and all affiliated organizations, their employees, agents and representatives, including volunteers and other drivers, from any and all claims, including negligence, arising from or relating to my child's participation in this event. This indemnification and hold harmless agreement does not apply to claims for intentional misconduct or gross negligence.

_____ _____ _____

(Print Parent's Name) (Parent's Signature) (Date)

NOTE: If your child has a food allergy, please provide an appropriate snack each day for their safety. Please fill out medical information on the back & return this form Checks can be written Holy Childhood of Jesus. Please contact the parish office at 231 526-2017 or religioused@cclcparishes.org with any questions.

FLIP OVER—FILL OUT OTHER SIDE OF SHEET

Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____

Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____

City: _____ State: _____ Zip: _____

Telephone: (___) _____ Emergency Telephone: (___) _____

Date of Birth: Month: _____ Day: _____ Year: _____

Family Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician Telephone: (___) _____

List allergies, medication, contacts, or other pertinent comments:

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ Signed: _____

(Parent or Guardian)