REGISTRATION FORM

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Telephone: ( ) _____ Cell ( ) _____

Home E-Mail: _____

Age: _____ **Date of Birth:** _____ **Grade:** _____

Parents Names: _____

In Case of an emergency, contact:
Name: _____**Number**_____
Relationship to child: _____

Allergies or other medical conditions: _____
_____

Home Church: _____

Video/Photo Release: My child may appear in videos/photos that may be posted:
Signed: _____

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for emergency treatment. I wish to be advised prior to any further treatment by a doctor or hospital. Signed _____