REGISTRATION FORM

Parents Names: _____

Children's Names/Age/Grade/Date of Birth:

1. _____
2. _____
3. _____
4. _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Cell ( ) _____

Home E-Mail: _____

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 _____