REGISTRATION FORM VACATION BIBLE SCHOOL

Mon. July 31st thru Friday Aug 4th (9:00AM to 11:45 AM)

MAKER FUN FACTORY

Grades K thru 5

$25 offering per child or $40 per family

Child's Name _____ **Gender**_____

Age ____ **D.O.B.** _____**Last school graded completed** _____

Parent's Names _____

Address_____

street city state zip

Phone 1 _____ **phone 2** _____

Email address _____

Allergies or medical conditions _____

_____

Emergency Contact _____

Phone _____**Relationship to Child**_____

T Shirt Size Youth: small_____ **medium** _____ **Large** _____

Adult: small_____ **medium** _____ **Large** _____

(please fill out consent for on reverse side)

Registration forms due July 15th

If you would like to volunteer contact Robert Ferri at robferrictk@gmail.com

(Consent Form on Reverse Side)

Parental/Guardian Consent Form and Liability Waiver

I,_____, grant permission for my child, _____,
to participate in this parish program. This activity will take place under the guidance of CTK volunteers.
As parent/legal guardian, I remain legally responsible for any actions taken by the above-named minor I agree on behalf of myself, my child named herein, or our heirs and successors to hold harmless and defend CTK parish and the Diocese of Providence, its volunteers associated with the program, arising from or in connection with my child's attending the program or connection with any illness or injury or cost of medical treatment in connection therein, and I agree to compensate the parish, its officers, directors, and the Diocese of Providence, volunteers associated with the program for reasonable attorney's fees and expenses arising in connection therein.

Signature:_____ Date:_____ Home Phone:_____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume responsibility for the health of my child. (Of the following statements, sign only those applicable.)
EMERGENCY MEDICAL TREATMENT: In the event of any emergency, I hereby give my permission to transport a child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment of the hospital or doctor.
FAMILY DOCTOR: _____ Phone: _____.

Family Health Plan Carrier:_____Policy #: _____.

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the _____ (Arch)Diocese, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to call collect (with any phone charges reversed to myself).

Signature:_____Date:_____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

Signature:_____Date:_____
No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature:_____Date:_____
I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature:_____Date:_____

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence.
Allergic reactions (medications, foods, plants, insects etc.) _____
Immunizations: Dates of last tetanus/diptheria _____
Does child have a medically prescribed diet? _____
Any physical limitations?_ _____
Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?
_____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.?

If so date and disease or condition:_____

You should be aware of these special medical conditions of my child: