



Registration Form

(One 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 cellphone: (_____) _____

Home email address: _____

Home church: _____

Crew number or name (for church use only): _____

Allergies or other medical conditions: _____



In case of emergency, contact: _____

Phone: _____

Relationship to child: _____

PHOTO INFORMATION

Please indicate whether or not your child's photograph may be included on website or in parish publications?
____ YES, you may use photographs of my child/children in parish publications and /or on the parish websites.
____ NO, please do not publish any photographs of my child/children.

CONSENT TO TREAT

I/We the undersigned parent(s)/guardian of _____, a minor, do hereby authorize treatment of my/our child by a licensed medical physician in case of any accident or illness that may so arise, or any hospitalization necessary.

Father/Legal Guardian

Mother/Legal Guardian

Date: _____ This consent form will remain effective until _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes...

- 1) **Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. My child will administer his/her own medication.

Signature: _____ Date: _____

- 2) I hereby grant permission for nonprescription medication (such as Tylenol[®], throat lozenges, cough syrup) to be given to my child, if deemed advisable.

Signature: _____ Date: _____

- 3) No medicating of any type whether prescription or nonprescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

Any known allergies?: _____

Any physical limitations?: _____

Any medically prescribed dietary needs?: _____

Are you a vegetarian? YES NO

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, fainting?
YES NO

If yes explain: _____