Vacation Bible School

Jubilee Year of St. Francis

<u>June 15-18, 2026</u> 8:00 a.m.–12:00 p.m. Snack and water will be served.	Open to children grades K- 4th (2025-26 school year).	Registration is $10 per child with $40 cap per family. (Checks payable to St. Stephen.)

June 15-17 held at St. Stephen Church and Activity Center

June 18 pilgrimage to the Solanus Casey Center
1780 Mount Elliott St., Detroit 48207

Volunteers are needed to help. Please contact the Director of Religious Education – Kim Gilliland at 734-753-4722

Help us out! Please consider donating small bottles of water to include with snack. Please label with "VBS" and leave in the church basement. Thank you!

** See back to register each child.**

*Please return form to the parish office or place in the collection basket no later than **June 5, 2026**.*

Family Name: _____ Home Phone: _____
Father's Name: _____ Cell Phone: _____
Mother's Name: _____ Cell Phone: _____
Address: _____
Email: _____
Emergency Contact: _____ Relation to Family: _____

Youth t-shirt sizing: Xsmall 2-4, small 6-8, medium 10-12, large 14-16, Xlarge 18 (Equal to Adult Small)

1.: _____ Age: ___25-26 Grade: ___ Shirt size: _____
Special Needs/Allergies: _____
2.: _____ Age: ___25-26 Grade: ___ Shirt size: _____
Special Needs/Allergies: _____
3.: _____ Age: ___25-26 Grade: ___ Shirt size: _____
Special Needs/Allergies: _____
4.: _____ Age: ___25-26 Grade: ___ Shirt size: _____
Special Needs/Allergies: _____

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. 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: _____

Emergency Phone(s): _____

Family Physician:_____ Phone: _____

Physician Address:_____ City: _____

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

_____

_____

Health Insurance Data:

Company:_____ Policy: _____

Group:_____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice 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. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date:_____ Signed: _____

(Parent or Guardian)