Our Lady of Grace * Vacation Bible School 2016 * July 25-29, 2016

REGISTRATION

Registration Fees are $40 per child for gr. K-8.
Max: $100 per family Checks payable to OLG.

Child's Name:	Age	Date of Birth

Address:	City	Zip

Home Phone:	School	Grade in Sept. 2015

Primary Email:

Mother's Name:	**Work Phone**	**Cell Phone**

Address (if different)	City	Zip

Father's Name:	**Work Phone**	**Cell Phone**

Address (if different)	City	Zip

Emergency Contact (**NOT** parents)	Phone	Cell

Registration fee includes a VBS T-shirt for each child registered. Please check the size needed for this person. (Each person has a separate registration form)

_____ Child Small (6-8)
_____ Child Medium (10-12)
_____ Child Large (14-16)

_____ Adult Small
_____ Adult Medium
_____ Adult Large
_____ Adult X-Large
_____ Adult XX-Large

Please circle session choice:

Morning Evening

VBS REGISTRATION FEES (K-8th Grade) FOR OFFICE USE ONLY

$40 per child (Max: $100 per family) Fee Paid _____

Siblings? Yes ___ No ___ Date Paid _____

PLEASE COMPLETE OTHER SIDE

Our Lady of Grace Religious Education
Emergency Information

MUST BE COMPLETED BY PARENT OR GUARDIAN

I, the parent/guardian of _____, give my permission for his/her participation in any and all Religious Education/Youth Ministry activities. I agree to direct my child to cooperate and conform with directions and instructions of Religious Education/Youth Ministry personnel responsible for said activities.

I agree that in the event that my child is injured as a result of his/her participation in Religious Education/Youth Ministry activities, including transportation to and from these activities, whether or not caused by the negligence of the parish Religious Education/Youth Ministry program, any of its agents and employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital, or medical insurance, or any available benefit of mine.

Mother's Signature _____ Date _____
Father's Signature _____ Date _____
Guardian's Signature _____ Date _____

Does your child have or is s/he subject to (check if yes):

_____ Asthma _____ Fainting Spell _____ Allergies
_____ Heart Trouble _____ Menstrual Problems _____ Diabetes
_____ Visual Difficulties _____ Digestion Difficulties
_____ Ear, Nose and Throat Problems
_____ Sports Restrictions (if yes, explain)
_____
_____

_____ Other (please specify)
_____
_____

Family Physician _____ Telephone _____
Address _____ City _____ Zip _____
Medical Plan _____ Plan Number _____

If you do not want medical care given to your children, state reason:
_____
_____

Relative or friend authorized to pick up child in the event of an emergency (other than parent):

Name _____ Telephone_____ Relationship _____

PLEASE COMPLETE OTHER SIDE