St. Brendan Parish VBS 2018– *SHIPWRECKED* Child Registration Form

Child's Name: _____ **M/F:** _____ **D.O.B**: _____

Grade in school in 2018-2019 (please circle one):

4-year-old Preschool Kindergarten 1st 2nd 3rd 4th 5th 6th

Parents' Names: _____

Address: _____

Email: _____ **Phone:**_____

Any known allergies: _____

Registration fee ($25.00 per child) is attached	Cash or Check #

Please make checks payable to *St. Brendan Church*.

Saint Brendan Parish Vacation Bible School

CONSENT AND RELEASE OF LIABILITY FOR USE OF MINOR'S LIKENESS AND OTHER INFORMATION

I (We) the parent(s) and/or guardian(s)hereby grant consent for St. Brendan Church ("Parish"), and/or its agents to record (in writing or otherwise), photograph, audiotape, or videotape my minor child's name, image, likeness, spoken words, student work, and/or performance, in any form, and to display, release, exhibit, publish, or distribute the same, or any part thereof, for the purpose of and in connection with any material that may be created by or on behalf of the Parish including, without limitation, Parish bulletin boards; the Parish's weekly bulletin; the Parish's website; print and electronic media; Parish marketing, public relations and communications materials and/or presentations; and such other uses as may not be contemplated herein, without further notice or compensation as follows:

□ I consent to all of the above.

□ I consent to all of the above, e*xcept*

_____.

□ I consent to only the following:

_____.

□ I do not consent to any of the above.

I further understand that by entering into this informed consent and release, and by granting permission as stated herein, I hereby release the Parish, the Diocese of Cleveland, and their respective officers, directors, agents and/or employees from and against any and all liability, loss, damage, costs, claims, and/or causes of action arising out of or related to the above items to which I have consented.

I further understand that the Parish and its respective officers, directors, agents and/or employees have no control over use of photographs, videotapes, audiotapes, or other records made by others and/or outside the scope of this consent and release.

Finally, in signing below I acknowledge that all recordings, audiotape, videotape, photographic proofs, photographic negatives, positives, and prints shall constitute the property of the Parish.

Name of Minor Student (please print): _____

Signature of Parent(s) or Legal Guardian(s): _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

Residing at: _____

MEDICAL FORM ON BACK MUST BE COMPLETED!

REGISTRATION DEADLINE is May 25, 2018

ST. BRENDAN PARISH - VACATION BIBLE SCHOOL 2018
EMERGENCY MEDICAL AUTHORIZATION FORM

Child's Name _____ Phone _____

Address _____ Zip _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while attending VBS classes when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN:

Mother _____ Phone _____
First Last

Father _____ Phone _____
First Last

Other _____ Phone _____
First Last

If I cannot be contacted and it is advisable to send my child home due to minor illness or injury, my child can be released to the following:

Name _____ Relationship _____ Phone _____

PART A OR B MUST BE COMPLETED

PART A: TO GRANT CONSENT FOR: CHILD'S NAME: _____

I hereby give consent for the following medical care providers to be called:

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

Medical Insurance Provider _____ No: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by: Dr. _____ (preferred doctor), or Dr. _____(preferred dentist) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to _____ _____(preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____
_____
_____

Date _____ Signature of Parent /Guardian _____

PART B: REFUSAL TO CONSENT FOR: CHILD'S NAME: _____

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the VBS Administrator to take the following action: _____
_____

Date _____ Signature of Parent/Guardian _____