Office use only-Received
Date: _____ Ck#_____
Credit: _____ Cash:_____
T-Shirt Size: _____

Student Information

Please return Registration From to the Parish office no later than May 24th

Fee: $35 for first Child, $30.00 each child after

Student Name_____

Birth date_____ Age____ Male___ Female___ Phone Number_____

Father/mother name_____

Address_____ City_____ Zip code_____

Email address_____

Is your family a registered member of St. Bernard's Parish? Yes No

Please circle LAST completed grade level for your child. (As of June 2017)

(Preschool Children must be 4 years old by August 1, 2017)

PRESCHOOL	KINDERGARTEN	1ST GRADE
2ND GRADE	3RD GRADE	4TH GRADE
5TH GRADE	6th GRADE	

PARENTS: Please indicate if you can help in any of the following areas:

CABIN LEADER Grade Level you would like to work in _____ (Must be fingerprinted with Diocese)

STATION LEADER Grade Level you would like to work in _____ (Must be fingerprinted with Diocese)

SNACK HELPERS: Help prepare and distribute snacks to the children from 10:00am to 11:30am.

Monday Tuesday Wednesday Thursday Friday

RECESS HELPERS: Help supervise the children in the play areas from 10:00am to 11:30am.

Monday Tuesday Wednesday Thursday Friday

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

AND TURN INTO CHURCH OFFICE NO LATER THEN MAY 24TH

St. Bernard's Parish Vacation Bible School

ACTIVITIES PERMISSION FORM

Participant's full name_____

I, the undersigned parent or legal guardian of the above named person gives my permission for his/her participation in Vacation Bible School offered by St. Bernard's parish from June 12, 2017 through June 16, 2017. I hereby release and save harmless St. Bernard's Rarish and any and all of its employees or volunteers from any and all liability for any and all harm arising to my child and for any loss of property as a result of said activities.

MEDICAL PERMISSION FORM

I, the undersigned parent or legal guardian of _____, a minor, do hereby appoint the Activity or VBS Director as agent for the undersigned for the sole purpose of authorizing and signing any consents for x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general supervision of any physician and surgeon licensed under the provision of the Medical Practice Act on the medical staff of the nearest Emergency Hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital; care being required but is given to provided authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which any physician in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the provisions of section 25.8 of the California Civil Code and shall remain effective from June 12, 2017 through June 16, 2017 unless sooner revoked in writing to said agent(s).

PARENT/ LEGAL GARDIAN SIGNATURE

_____ _____

Signature Date

NECESSARY MEDICAL INFORMATION

1. Student full Name_____ DOB_____

2. In case of accident call_____ Home #_____ WK#_____

3. Alternate person to call_____ Tele#_____

4. Physician Name_____ Tele #_____

5. Insurance Carrier_____ Policy #_____

6. Describe in full any allergies (drug, food, insect bites, etc.) or limitation on physical activities.

Drug allergies:_____

Food allergies:_____

Other allergies:_____

Physical limitations:_____

Current Medications:_____

Please return registration form no later than 05-24-16 to the Parish Office.
PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.