Form 9 Child and Youth Registration Form

CHILD LAST NAME FIRST

Program Year September 20___ - August 20____

DOB: ____________ Grade: ________________ School: ______________________________________

cell #(youth) _______________________email(youth)________________________

Parent/Guardian: ____

Address: ____

Phone: (home) _____________________ (cell /work) _________________

E-mail: _________________________________

Parent/Guardian: ____

Address: ____

Phone: (home) ______________________ (cell / work) ____________________

E-mail: ______________________________

In the event parent/guardian cannot be reached:

Emergency Contact #1: ____

Phone: (home) _____________________ (cell/work) ____________________________________

Relationship to Child ____

Emergency Contact #1: ____

Phone: (home) _____________________ (cell/work) ____________________________________

Relationship to Child ____

\+ +

General Field Trip Permission: I hereby give permission for the youth listed below to accompany his/her church group on field trip events as planned by Cross Roads Presbyterian Church throughout the program year. I understand I will be notified in advance of specific individual events/activities and will complete, sign and return specific permission forms.

Youth name____

Form 9 Child and Youth Registration Form

CHILD LAST NAME FIRST

Medical Release: I, the undersigned parent/guardian of the youth listed on this form do hereby give permission for any Cross Roads Presbyterian Church approved adults to treat said youth for minor injuries and to take him/her to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to the health of the child. I consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care that may be rendered to said minor, under the general specific instructions of _____(name of participant's physician) or if unavailable, by an on-call physician at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, of said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment. Delivered to said persons entrusted with the care, custody and control of said minor child, this consent will remain effective until the ____ day of _____ of 20__. I understand that any and all medical expenses incurred are my responsibility and that there is no medical insurance coverage provided by Cross Roads Presbyterian Church.

Further, as parent/guardian of the named above, I do hereby consent that my child may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

Signature of parent/guardian: _____ Date: _____

PHOTO/VIDEO RECORDING RELEASE

From time to time during the year, we put pictures/videos in the local newspaper, on cable TV, on our church website, and other media platforms to advertise upcoming events. These pictures are usually taken in the classroom showing the children involved in some special school activity. To have your child participate, if he/she is chosen, please complete the following statement.

I give permission for my child's image to be used. (Initial) _____ YES or NO _____

I give permission for my child to sign herself / himself out of church programs when his/her guardian is in the building. (Initial) _____ YES or NO _____

MEDICAL DATA

Physician: _____ Phone #: _____

Medical Insurance Name:_____

Name of Insured:_____

Group #_____Policy #_____

Form 9 Child and Youth Registration Form

CHILD LAST NAME FIRST

Health History:

Check those that apply:

____ Asthma	____ Convulsions	____ Diabetes
____ Ear Infections	____ Epilepsy	____ Emotional Issues
____ Fainting	____ Hearing Impairment	____ Heart Disease/Defects
____ Menstrual Cramps	____ Migraines/Headaches	_____Motion Sickness
____ Nosebleeds	____ Sleep Walking	____ Special Dietary Regimen
____ Wears Contact Lenses	____ Wears Glasses	

____ Other (specify) _____

Allergies (check those that apply)

____ 1. Animals	____ 5. Hay Fever
____ 2. Insect Stings	____ 6. Pollen
____ 3. Plants	____ 7. Food
____ 4. Medicine/Drugs	_____8. Other Allergies

Detailed Information for anything that is checked above in health history or allergies section

_____

_____

_____

_____

Medications_____

_____

_____

The information contained in this document shall be treated as privileged and confidential. It is intended solely for the use of authorized persons of Cross Roads Presbyterian Church. Any review, dissemination, distribution, or duplication by unauthorized personnel is prohibited.

A COPY OF THIS FORM WILL BE TAKEN ON EVERY ACTIVITY, FIELD TRIP OR OVERNIGHT EVENT THAT THIS YOUTH ATTENDS.

Parent/Guardian Signature _____Date_____