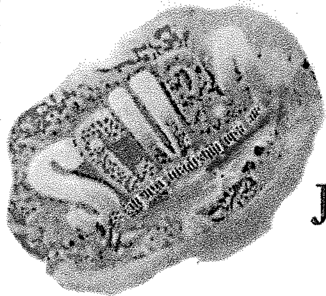
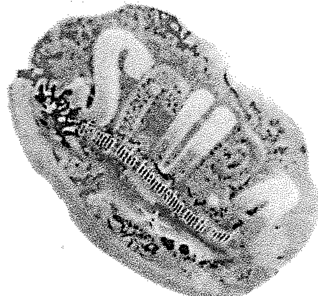


St. Mark's VBS

June 24-28, Program June 30th

Please fill out 1 form per child



Date_______________

Child's Name (First & Last) ___________________ Preferred Name to be called __________

Primary Phone ___________________ Home/Cell DOB (mm/day/year) ____/_____/____

Address _____________________________ City ____________ State _______ Zip______

Parents/ Guardian Information

Mother's Name_________________________ Father's Name_______________________

Alternative Phone (Mother)________________ (Father) __________________

Email Address _____________________________ Best Person to Contact for the Program

& Best Phone Number to Reach that Person _____________________________________

Whom Will be bringing the Child to the Program_______________________________

Relationship to Child___________________________

What Church is the Child Affiliated with_________________________ Does any known

Relatives Attend St. Mark's Lutheran Church Yes/No if Yes Their Name Is _______________

Who Is Allowed to Pick Up Child Other than Parents _________________________________

____

Siblings ____

Child's Previous Group Experience with the Program Y/N If Yes how many years___________

Parent/Family Information: Are you willing to Help Out Yes / No we need lots of volunteers

If Yes where would you be willing to help out the most, Music, Story time, Games, Crafts, Classroom Group Leader/ Classroom Lead.

Where would you be willing to help out the weeks required to volunteer __________________

Shelley D. O'Donnell (Director of Youth Programs)
St. Mark's Lutheran Church
201 West Jefferson Street
Butler, Pa 16001

Medical/Additional Information

Child's Name ________________________________ Sex Male/Female

Date of Birth (mth/day/yr) ___/___/20___

Any Known Allergies Yes/No If Yes what Are they __________________________

Does the Child carry and Epipen Yes/No

Is the Child on any Medication Yes/NO if Yes What is the Medication ___________________

Has Your Child had Vaccines Yes/No Any Vision/ Hearing or Speech Difficulties Yes/ No

If Yes Please Explain ____

First Aid/ Medical Care and/or Treatment Consent

I authorize staff in the program to give my child first aid when appropriate. I understand that every effort will be made to contact the parents in the event of an emergency requiring medical attention to the child. However, if the parents/ guardian cannot be reached I hereby authorize the Program staff to get transportation to the nearest Medical Care Facility and to secure necessary medical treatment for my child.

I authorize all medical, diagnostic, surgical and hospital procedures as may be performed or prescribed by a treating physician if I cannot be reached in the event of an emergency.

Date_______________________________ Signature_____________________________

I give permission to use finger paints and other Non-toxic Art/Craft materials Yes / No

I give permission to have pictures taken of my Child and have them Placed in the Church Newsletters, Bulletins, Website, Facebook, Instagram and to Share my Child's First Name Only for Publications Listed above. Yes / No

Parent / Guardian's

Name (Print) ____

Signature ____

Date_____________________