

# ACE- VBS Day Camp Registration Form

(One Per Child)

Child's name: \_\_\_\_\_ Child's Gender: \_\_\_\_\_

T-Shirt size \_\_\_\_\_ Child's age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Last school grade completed: \_\_\_\_\_

Name of parent(s): \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home telephone: (\_\_\_\_) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ Work phone: \_\_\_\_\_

Home Congregation (church & city) \_\_\_\_\_

Parent location while child is at camp (work, home, etc.) \_\_\_\_\_

Name of special friend your child would like to be with: \_\_\_\_\_

Name of persons other than parents to whom child may be released.

1. \_\_\_\_\_ 2. \_\_\_\_\_

Name of individuals child CANNOT be released to.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Family Permission to Photograph/Videotape- Release to Utilize**

We grant permission for any photographs or videotapes of our child as he/she is involved in VBS activities during the week of July 10-14, 2017, to be used in "telling the story" of ACE- VBS, in participating church web-sites, newsletters and other media releases.

\_\_\_\_\_  
Parent/guardian signature

**PRE-REGISTRATION IS ENCOURAGED.**

Allergies (food, medications or other include insect stings, hay fever, asthma):

Other medical conditions (behavioral, emotional or mental health problems):



Emergency contact person if unable to contact parents:

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Any activity restrictions? \_\_\_\_\_

Any recent illness, injury, or infectious disease? \_\_\_\_\_

Additional information \_\_\_\_\_

Insurance Carrier/Plan name & Group # \_\_\_\_\_

Has participant had the necessary immunizations to attend school? \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Medications to be given while at camp:

| <u>Medication</u> | <u>Dose</u> | <u>Frequency</u> | <u>Reason for taking medication</u> |
|-------------------|-------------|------------------|-------------------------------------|
|                   |             |                  |                                     |
|                   |             |                  |                                     |
|                   |             |                  |                                     |

All medications must be in original containers with participant name on label.

**THE FOLLOWING MUST BE COMPLETED FOR ATTENDANCE.**

This health history is correct and complete as far as I know. \_\_\_\_\_ has permission to engage in all camp activities except as noted. The Church leader has permission to provide routine health care & administer prescribed medications. In the event I cannot be reached in an emergency, I give permission to the Church leader to seek emergency medical treatment. I give permission to the physician selected by the Church leader, to secure and administer treatment for the person named above.

\_\_\_\_\_  
**Parent Signature**