

**ST. LEONARD FAITH COMMUNITY  
VACATION BIBLE SCHOOL  
JUNE 21-25, 2015  
6:00 – 8:30 PM**

**PARTICIPANT REGISTRATION FORM**

PARENTS' NAMES: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

NAMES OF CHILDREN	GRADE IN SEPT.	AGE	DATE OF BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD BE CONTACTED?

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATION TO CHILD: \_\_\_\_\_

DOES YOUR CHILD HAVE ANY HEALTH CONCERNS, FOOD ALLERGIES OR SPECIAL NEEDS OF WHICH WE SHOULD BE AWARE?

\_\_\_\_\_

WOULD YOU BE WILLING TO BRING A SNACK OR CRAFT ITEM IF CONTACTED?

\_\_\_\_\_ YES \_\_\_\_\_ NO

**A FREEWILL DONATION OF \$10 PER STUDENT IS REQUESTED  
TO OFFSET THE COST OF SUPPLIES.**

**THANK YOU FOR YOUR GENEROSITY.**

**PLEASE SEE REVERSE FOR THE EMERGENCY MEDICAL AUTHORIZATION  
FORM AND THE PHOTO RELEASE FORM.**

**THIS INFORMATION MUST BE COMPLETE IN ORDER FOR YOUR CHILD(REN)  
TO PARTICIPATE IN ST. LEONARD'S VACATION BIBLE SCHOOL.**

**EMERGENCY MEDICAL AUTHORIZATION FORM**

St. Leonard Faith Community Vacation Bible School 2015

Student Name \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under VBS authority, when parents or guardians cannot be reached.

**RESIDENTIAL PARENT OR GUARDIAN**

Mother's name: \_\_\_\_\_ Phone \_\_\_\_\_  
Father's name: \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

**TO GRANT CONSENT**

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

Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_  
Hospital \_\_\_\_\_ Phone \_\_\_\_\_

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 above named doctors, 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 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 or Guardian \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**REFUSAL TO CONSENT**

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 school authorities to take the following action: \_\_\_\_\_  
\_\_\_\_\_.

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

# PHOTO RELEASE

I hereby grant St. Leonard Faith Community and the Archdiocese of Cincinnati ("the Church") permission to use my likeness in any photograph, video or other digital or print reproduction the Materials") in any and all of its publications, including websites, without payment or any other consideration. I understand and agree that the Materials will become the property of the Church and will not be returned. I hereby irrevocably authorize the Church to edit, alter, copy, exhibit, publish or distribute the Materials for purposes of publicizing its programs or for any other lawful purpose.

In addition, I waive the right to inspect or approve the Materials and to receive any royalties or other compensation arising or related to the use of the Materials. I hereby hold harmless and release the Church and its representatives from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name)

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of \_\_\_\_\_,  
named above, and do hereby give my consent without reservation to the foregoing on behalf of  
this person.

\_\_\_\_\_  
(Parent/Guardian's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian's Printed Name)