

ST. Peter's United Methodist Church

4th & 5th Grade Fellowship Registration

Child's Name _____ Birth Date _____ Gender: M/F _____

Grade ____ School Attending _____ E-mail Address _____

Address _____ City _____ Zip _____ Home Phone # _____

Church Membership _____ Friend(s) attending with _____

Mother's Name _____ Home # _____ Work # _____ Cell # _____

Father's Name _____ Home # _____ Work # _____ Cell # _____

Emergency Contact Name _____ Home # _____ Cell # _____

Transportation Consent

I hereby give permission for my child, _____, to participate in activities with the St. Peter's 4th & 5th Grade Fellowship. I understand that my child may be transported to and from these activities in vehicles operated by individuals who are willing to support our Children's program. I agree to release St. Peter's United Methodist Church, its volunteers, and their staffs from any and all liability for my child while these activities are in progress, including transportation to and from the sites.

Parent Signature: _____ Date: _____

Consent for Emergency Treatment & Medical Card Information

Authorization of Consent to Treat a Minor: I, the undersigned, parent/guardian of, _____, a minor, do hereby authorize the bearer of this form as agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and medical care, including the general or special supervision of any licensed physician/surgeon, nurses, or other licensed practitioners of the healing arts, whether such diagnosis or treatment is rendered at the offices of said physician/surgeon or at a hospital, or elsewhere. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power on the part of my aforesaid agent to give specific consent to any and all such diagnosis, treatment of medical of which the aforementioned physician/surgeon, nurses, or other licensed practitioners of the healing arts, in the exercise of his/her best judgment may deem advisable. I hereby authorize any hospital, which has provided treatment to the above-named minor to surrender physical custody of said minor to my above-named agent upon completion of treatment.

Physician _____ Phone# _____ Hospital Preference _____

Allergies _____ Medications _____ Medical Condition /Special Need _____

Medical Insurance Carrier _____ Group # _____

Name of Insured _____ Insurance Authorization Phone # _____

Parent Signature: _____ Date: _____

Authorization to Photograph

I give authorization to photograph my child during participation in 4th & 5th Grade Fellowship activities. These photographs may be used in the community, church paper, bulletins, bulletin boards on church property, and/or church website.

Parent Signature: _____ Date: _____