

St. Peter's United Methodist Church
oFriday Night Friendso
Registration & Emergency Form

Child's Name (1): _____ Age: _____ Date of Birth: _____

Child's Name (2): _____ Age: _____ Date of Birth: _____

Child's Name (3): _____ Age: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Home Address: _____ City: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone#1: _____ Cell Phone#2: _____

Child's Special Needs/concerns:

Child's Allergies:

Child's Likes/Dislikes:

Medical Insurance Carrier: _____ Group #:

Name of Insured:

Insurance Company Phone #:

Physician's Name: _____ Phone #:

If you cannot be reached at the above referenced number(s) for an emergency, we may contact the following individuals:

Name: _____ Relation: _____ Phone:

Name: _____ Relation: _____ Phone:

AUTHORIZATION OF CONSENT TO TREAT A MINOR: I hereby authorize St. Peter's United Methodist Church to take my child(ren) to any licensed physician or hospital in the event of a medical emergency, if parent and contact cannot be reached.

Signature of Parent or Legal Guardian: _____ Date: