Astoria Central City VBS

2018 REGISTRATION FORM

Students Name: _____

Address:_____

Fall Grade Entering:_____BirthDate:_____

Age: _____

Allergy/Health Conditions: _____

_____

_____

Parent/Guardian Name: _____

Would you like to help with VBS? If so, where? _____

_____

Would you be interested in a 3rd thru 6th Grade youth group? YES_____

Can we contact you with more information? YES_____

Home Phone: _____Work Phone: _____

Cell Phone: _____Email: _____

Emergency Contact: _____

Relationship to the Child: _____

Emergency Contact Phone #: _____

The cost is $15 for individuals or $25 for families.

Medical Release Statement:

In case of a medical emergency, I understand every reasonable effort will be made to contact me. In the event that I cannot be reached through reasonable efforts, I hereby give my permission to the physician selected by the program director to secure proper treatment or to hospitalize, to order injections, anesthesia, or surgery for my child. On behalf of the parents/guardians, I further agree that I will not hold the sponsoring churches of the Astoria Central City VBS, their agents or employees, responsible for any accident or injury.

Medical Release Statement – Agree?: _____

Pediatrician's Name and Phone #: _____

_____

Photographs:

We take photographs through VBS week to put on our website. In addition, we produce a brochure for the parents to see the various activities that their child has participated in and to promote next year's VBS.

Permission to Publish Your Child's Photograph? _____

Signature of Parent/Guardian: _____

Date of Medical Release Agreement: _____

Comments: _____

Registration Forms may be returned to your churches or mailed to:

FBC Astoria

PO Box 117

Astoria, Or 97103