



# “Mighty Fortress, In Jesus, the Victory Is Won!”

## Vacation Bible School Registration Form

Kindergarten – 5<sup>th</sup> grade      Date: July 31 – August 3

Time: 9:00 a.m.–12:00 noon

Location: St. Gabriel East Campus

Cost: \$12/child or \$30/family (3 or more children)

*Financial assistance is available*

**Each child registered by June 26<sup>th</sup> will receive a t-shirt.**

(Make check payable to St. Gabriel Parish)

## Student Information

Child's Name

Grade (Fall 17)

T-Shirt Size

Child S, M, L or Adult S

Circle one

- |          |       |   |   |   |    |
|----------|-------|---|---|---|----|
| 1. _____ | _____ | S | M | L | AS |
| 2. _____ | _____ | S | M | L | AS |
| 3. _____ | _____ | S | M | L | AS |
| 4. _____ | _____ | S | M | L | AS |

## Family Information

Mother's name: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Father's name: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Family address: \_\_\_\_\_  
\_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



**Please fill out Medical Treatment Release Form on back also.**

**Registration is due to Parish Center by: Monday, June 26, 2017**

# Medical Treatment Release Form



To Whom It May Concern:

As a parent or guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency, which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Reason for which release is intended: St. Gabriel Parish Vacation Bible School

Family Information:

Address of minor(s): \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone \_\_\_\_\_

Family physician: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

Name of 1st minor: \_\_\_\_\_ Relationship to you \_\_\_\_\_

Name of 2nd minor: \_\_\_\_\_ Relationship to you \_\_\_\_\_

Name of 3rd minor: \_\_\_\_\_ Relationship to you \_\_\_\_\_

Name of 4th minor: \_\_\_\_\_ Relationship to you \_\_\_\_\_

Please list any allergies, medication, contacts or other concerns below (Make sure to indicate about which child you are referring):

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Health Insurance Data:

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

This release is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(Parent or Guardian)

