

# VBS REGISTRATION & PICKUP AUTHORIZATION FORM

Aug 7 - 10, 2017, 5:30-7:30 PM

3 Years Old - 6th Grade

## GALILEE LUTHERAN CHURCH - ELCA

Name: \_\_\_\_\_ Grade Completing \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Donation Paid \$ \_\_\_\_\_

I hereby enroll and give permission for my child to participate in the planned VBS activities of Galilee Lutheran Church-ELCA. I understand I am responsible for transportation to and from VBS.

\_\_\_\_\_  
**Signature** of Parent/Guardian

\_\_\_\_\_  
Date

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### PICK-UP AUTHORIZATION

I hereby authorize the following adults to pick up my child from VBS:

Name	Phone number	Relation to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there are any special instructions, or any persons who are **never** to be authorized to pick up your child, please list here:

\_\_\_\_\_  
\_\_\_\_\_

**Signature** of Parent/Guardian: \_\_\_\_\_

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**GALILEE LUTHERAN CHURCH - ELCA  
VBS REGISTRATION & HEALTH FORM**

**Aug 7 - 10, 2017, 5:30-7:30 PM**

**3 Years Old - 6th Grade**

*Must be Signed by an Adult Guardian*

NAME \_\_\_\_\_ GENDER: \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
Parent/Guardian Names \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

I hereby enroll and give permission for my child to participate in the planned VBS activities of Galilee Lutheran Church. I understand I am responsible for transportation to and from VBS.

\_\_\_\_\_  
**Signature** of Parent or Guardian **Date**

If parent/guardians are not available in the event of an emergency, notify:  
NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
ADDRESS \_\_\_\_\_ RELATION TO CHILD: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**HEALTH HISTORY (To be completed by parent or guardian)**

1. Has the camper been subject to medical treatment for any of the following:

Diabetes	( )	Ear Trouble	( )	Seizures	( )
Allergies	( )	Poison Ivy	( )	Throat or sinus	( )
Asthma	( )	Behavior	( )	Bee Sting	( )

Please explain any of the above \_\_\_\_\_

2. IMMUNIZATION RECORD (Give Dates)

Tetanus DPT \_\_\_\_\_ Polio \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_

3. ALLERGIES: (Please describe any conditions and treatments)

\_\_\_\_\_

1. MEDICATIONS: Drug name, dose, schedule (medication must be brought in original prescription package. Meds will ONLY be distributed by Church staff)

\_\_\_\_\_

5. Please explain conditions requiring medication or other condition requiring special care \_\_\_\_\_

\_\_\_\_\_

PARENTAL AUTHORIZATION - In the case of a medical emergency, I understand every effort will be made to contact the parents or guardians of the camper. In the event that I cannot be reached, I hereby give permission to the medical examiner selected by the church staff to hospitalize, to secure proper treatment for, to order injection, anesthesia, or surgery for my child as named on this form.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_