FAMILY NAME:________________

St. Kenneth's
VACATION BIBLE SCHOOL

JUNE 19-23
9:30am – 12:30pm
(For children entering K-5th grade in September)

Mom's name: ____________________Mom's cell phone#: ___________________
Dad's name: _____________________ Dad's cell phone#: ___________________
Home address: ____
E-mail address: ____

Childs #1 name: ___________________ Grade entering in fall 2017: _______
Please list any special or medical needs as well as any food allergies below: (a snack will be provided)
____
____

Childs #2 name: ___________________ Grade entering in fall 2017: _______
Please list any special or medical needs as well as any food allergies below: (a snack will be provided)
____
____

Emergency Contact: **(person other than the parent)**
Name: ______________________________ Phone #: ________________

Name of person who will be picking up your child?_________________________

*Registration fee is **$35 for first child, $30 for each additional child.**

Please make checks payable to: **St. Kenneth Faith Formation**
Any questions Please Contact Betty Berryman at 734-420-3031

over please

FAMILY NAME:________________

Special notes or requests:

____

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____

Photo Permission: I release St. Kenneth Parish of all liability and give my permission to have pictures of my child/family on the St. Kenneth website or in the church bulletin. (Names will not be used) Yes ☐ No ☐

Parent Signature ____________________________________Date ____________________

Office use only: Date __________ Amount Paid __________ Check/Cash __________

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:
As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: ______________________________ Relationship to you: __________________
Reason for which release is intended: ____
Address of Minor: __________________________________ City: _________________________
Emergency Phone(s): _______________________________
Family Physician: ___________________________________ Phone: _______________________
Physician Address: __________________________________ City: _________________________

List allergies, medication, contract, or other pertinent comments:

____

____

Health Insurance Data:
Company: ______________________________ Policy: ______________________________
Group: ________________________________ Contract: _____________________________

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: __________________________ Signed: ______________________________
(Parent or Guardian)

PSI/MedRel/05-94
HAPS-March 2004

FAMILY NAME:____________________