

EMERGENCY INFORMATION: (when the parent/guardian cannot be reached)

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Health Insurance Provider: _____ Policy/Medical Number: _____

Family Physician Name: _____ Phone: _____

Does your child have any special needs? IEP?

Does your child have any allergies or medical concerns? (Especially food allergies)

EMERGENCY HEALTH / MEDICAL INFORMATION AND CONSENT:

In the event of an emergency, I, the undersigned parent/guardian of the child named on this form, hereby give permission to St. Clare Catholic Church, and their employees, agents, representatives, and adult volunteers, to arrange for and authorize emergency medical, dental, or surgical treatment for my child, as considered necessary by the attending physician. I wish to be advised prior to any further treatment by the hospital or doctor.

CONSENT TO PARTICIPATE:

By signing on the above below, I consent to have my child participate in St. Clare's VBS program and will allow photographs to be taken of my child to use for parish purposes only. My child's picture may be taken for the church bulletin, website, for arts and crafts activities, and for promotion of future VBS programs at St. Clare.

Signature of parent/guardian: _____ **Date:** _____

(Office Use Only):

ENVELOPE # _____

Pmt rec'd: \$ _____ date: _____ Check #: _____

Number of children attending VBS: _____

(Office Use Only)

CREW: _____