VACATION BIBLE SCHOOL 2019

FOR AGES PRE-K (4 YRS) through entering 6TH GRADE

Queen of the Holy Rosary Parish, Hostyn & Sts. Peter & Paul Parish, Plum

936 FM 2436 La Grange, TX 78945 hostynch@cvctx.com 979-247-4441 FAX 979-247-5008

Hostyn Parish Hall July 8 – 12, 2019 8:00 a.m. – 12:00 p.m.

Please Register by June 24, 2019 Late registration taken until July 3 if space is available.

VBS COST: FREE! You are invited to help with refreshments.

PARISH: ___ Sts. Peter & Paul, Plum ___ Queen of the Holy Rosary, Hostyn ____ OTHER(List) _____

STUDENT'S NAME: _____

ADDRESS & HOME PHONE: _____ _____

DATE OF BIRTH: _____ AGE: _____ LAST GRADE COMPLETED: _____

NAME of Parent/Guardian_____ Daytime Phone _____

NAME of Parent/Guardian_____ Daytime Phone _____

Other Phone _____ Email _____

EMERGENCY CONTACT PERSON/TELEPHONE: _____ _____

EMERGENCY CONTACT PERSON/TELEPHONE: _____ _____

Photo Disclaimer: I hereby give permission for my son/daughter to be photographed or videotaped. I realize that the photo may be published in a newsletter or other publications, or shown on the parish website or bulletin board. The photos/video may be used for educational or informational purposes regarding the programs at the Diocese of Victoria or its Parishes.

PERMISSION FORM/MEDICAL RELEASE

I hereby consent to participation by my son/daughter, in VBS sponsored by Queen of the Holy Rosary Church and Sts. Peter & Paul Church of the Diocese of Victoria. I understand that my son/daughter will be under the supervision of diocesan and parish personnel. As parent or legal guardian I agree to defend, indemnify and hold harmless the Diocese or Queen of the Holy Rosary or Sts. Peter & Paul, its' clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my son/daughter's participation in these activities.

I grant permission for non-prescriptive medication (e.g. Tylenol, throat lozenges, Pepto-Bismol, etc.) and routine nonsurgical medical care to be given to my son/daughter if deemed advisable by the supervising personnel. I understand that all meds will be collected and disbursed by an adult staff member. (No meds should be in the possession of a participant with the exception of inhalers.) In case of an emergency, I also grant permission to transport my child to the nearest hospital for emergency medical or surgical treatment and for an authorized adult sponsor to sign for treatment if I cannot be located.

KNOWN ALLERGIES (to FOOD or to DRUGS) **OR OTHER MEDICAL CONCERNS/ PHYSICAL LIMITATIONS:**:

_____

My son/daughter takes the following medication (name, dosage):_____

This medication is for:_____

Last immunization/booster for Diphtheria/Tetanus:_____

Family Physician _____ Phone (_____)_____

Address _____

Name of Insurance Company: _____ Phone (_____)_____

Name of Insured _____ Policy/Group # _____

_____ _____

Parent / Guardian Signature Date

_____ _____

Parent / Guardian Signature Date