

VBS 2018 Registration Form



Dates / Location: **June 11-15 9:00 am-noon Mon-Fri**
@ Holy Rosary Church
1416 George St., Rosenberg, TX 77471
CCE Office phone: 281-342-3089 x. 141

Type of Registration:

- Child Participant (ages 3-incoming 5th grade) Teen Helper (completed 5th grade-age 18)
****Preschoolers must be potty trained **Teens over age 18 register and talk to Mrs. Leann**

Child/Teen's Information:

Name: _____

Sex: (circle one) M F Age: _____ Incoming Grade: _____

T-shirt size: (circle one) child sizes: XS S M L / adult sizes: S M L XL XXL

Family Information:

Parent/Guardian Name(s): _____

Home Address: _____

Registered Parishioners of Holy Rosary? _____

Best Contact Info:

Mom Phone: _____ work cell - Texts OK? _____

Dad Phone: _____ work cell - Texts OK? _____

Emergency Contact: other than parents

Name: _____ Relationship: _____

Phone: _____

People authorized to pick up your children from VBS:

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Special info we need to know so your child has a great VBS week: ex: fears, special needs, medical issues, etc.

Registration is **\$25.00** per child/**\$65.00** per family of three or more children (must be siblings, not cousins).
Please make checks payable to Holy Rosary Church. (***teen helpers must register and pay**)

****Registrations turned in before Monday, June 4th will include a t-shirt****

Only limited t-shirts will be available for sale for registrations turned in after June 4th!

Date received: _____
Payment: _____

Archdiocese of Galveston-Houston Office of Adolescent Catechesis and Evangelization

PARENTAL/GUARDIAN CONSENT FORM & LIABILITY WAIVER

Child 1: Name _____ Date of Birth _____ Grade _____ Age _____ Sex _____
 Child 2: Name _____ Date of Birth _____ Grade _____ Age _____ Sex _____
 Child 3: Name _____ Date of Birth _____ Grade _____ Age _____ Sex _____
 Home Address _____ Primary Phone _____
 City/Zip Code _____ Alternate Phone Number: _____
 Parent(s)/Guardian(s) Names _____
 Family Email Address _____

CONSENT & LIABILITY WAIVER

**Important! To be filled out by the Parent/Guardian for youth under 18 years of age.
 (If participant is 18 years of age or older, consent must be signed by the individual)**

I (name of parent/guardian) _____, grant permission for my child, (participants' name),
 _____ to participate in (event) VBS 2018 to be held (date) June 11-15, 2018
 (time) 9am-noon at (location) Holy Rosary Catholic Church 1416 George St., Rosenberg, TX 77471

In consideration of my child's participation in this event, I agree on behalf of myself, my child named herein, and our heirs, successors, and assigns to indemnify, hold harmless and defend the Archdiocese of Galveston-Houston, the sponsoring parish, its pastor, youth ministry leader, principal, other agents, employees or other representatives associated with the event from any and all injuries, losses or claims arising out of my child's participation in the event.

In signing this form I certify that all information contained herein is true and accurate to the best of my knowledge.

Signature (Parent/Guardian) **Date**

YOUTH PARTICIPANT: In signing the line below I agree to abide by any/all policies and rules established for this event/activity (see Code of Conduct). Should I not be able to maintain the guidelines and expectations of the adults and my peers, I understand that there will be consequences for my actions, including being removed from the activity and being sent home at my parent's expense.

Signature (Youth Participant Grade 6 and older) **Date**

VIDEO/PHOTOGRAPHY CONSENT

As parent/guardian, I understand that promotional pictures and videos (individual and group) will be taken during this event. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, web page, calendars, power point, video etc.) in highlighting the event.

Signature (Parent/Guardian) **Date**

Medical Matters (Please specify Child's name)

I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor and I understand that all financial obligations are my responsibility.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship _____ Phone _____

Family Doctor _____ Phone _____

Medications

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows

My child is taking the following medication at the present time.

Medication(s): _____ Dosage: _____

Administer: _____

_____ I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information: (Archdiocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

- Has had an episode of the following or has been diagnosed: Seizures Asthma Diabetic
- Allergic reactions to the following (foods, dyes, latex etc.) _____
- Has had a medical surgery within the last six months? Yes No Still under doctor's care? Yes No
- Has a medically prescribed diet? _____
- The following physical limitations? _____
- Immunizations current and up to date: Yes No Date of last tetanus/diphtheria immunization _____
- You should also be aware of these special medical conditions of my child (e.g. depression, anxiety, etc.): _____

Insurance Information: **No, I do not carry medical insurance at this time.**

Insurance Carrier: _____ Name of Insured: _____

Insurance Policy Number: _____

Father's Name: _____ Cell Phone: _____

Mother's Name: _____ Cell Phone: _____

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself). I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

Signature (Parent/Guardian) Parent/Guardian must sign for anyone under 18 years of age.

Date

Signature (Participant 18 years of age or older must sign own consent)

Date