

# REGISTRATION

PLEASE FILL OUT ONE FORM PER STUDENT – A Knight in Faith

Name \_\_\_\_\_ Name Preferred \_\_\_\_\_

Student's School \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Parent Work Phone (\_\_\_\_\_) \_\_\_\_\_

Parent Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Parent E-Mail \_\_\_\_\_

Student's Age \_\_\_\_\_ Birthday \_\_\_\_\_ Grade Entering in Fall \_\_\_\_\_ T-shirt size \_\_\_\_\_

Are there any other family members involved with A Night in Faith? If so, please list.

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Emergency Contact (other than a parent) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Health Concerns or Allergies (Please list all)

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Other Requests \_\_\_\_\_

# Authorization Consenting to Medical Treatment

In effect August 1<sup>st</sup> 2010 through July 31<sup>st</sup> 2011

## **Please Print**

I/we \_\_\_\_\_ and \_\_\_\_\_ are the natural parent(s) or

legal guardian(s) having legal custody of \_\_\_\_\_ who resides with me/us  
(Student's Name)

at \_\_\_\_\_  
(Address) (City) (State) (Zip)

give our permission for a licensed doctor, physician, or emergency treatment center, selected by the person in charge of any Stone Creek Church event, to administer the necessary attention and aid IMMEDIATELY to our student should he/she become injured or sick at any Stone Creek Church activity during the dates of August 1<sup>st</sup> 2010 and July 31<sup>st</sup> 2011 and to do so without having to wait until we are contacted. I/we the parent(s) or legal guardian(s) consent to X-rays, examination, anesthetic, medical or surgical diagnosis, treatment and hospital care.

I/We understand the activity director will endeavor to reach us should the nature of the injury or illness warrant it. However, we will not hold any of the activity personnel responsible if efforts to contact me/us are unsuccessful.

Video and Photo Release: I understand photographs may be taken of my child and a video may be produced and used for ministry purposes.

Date \_\_\_\_\_ Father/Guardian \_\_\_\_\_  
(Signature)

Date \_\_\_\_\_ Mother/Guardian \_\_\_\_\_  
(Signature)

## **Other Information**

Father's Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Nearest Relative to Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Student's Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Location \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Id# \_\_\_\_\_

Allergies or any other health concerns \_\_\_\_\_  
\_\_\_\_\_

Any medication student is presently taking \_\_\_\_\_

RX# \_\_\_\_\_ for \_\_\_\_\_