

## 2010 VBS Registration Form

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

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CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

Name of relative, neighbor, we can contact if needed:

CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

### Informal Guardian Authorization Consent for Treatment

In the event that my child \_\_\_\_\_ becomes ill or sustains an injury while in the care of THE CHURCH OF THE CRUCIFIED ONE, 20 VT Route 100 South, Moretown, VT (PHONE: 802-495-4516), I, the undersigned, grant the authority to THE CHURCH OF THE CRUCIFIED ONE to act on my behalf in obtaining and consenting to any medical treatment that may be necessary, including, but not limited to: X-ray examination, anesthetic, medical, dental, or surgical diagnosis and treatment, hospital care, administration of drugs or medicine, under the supervisions and upon the advice of a duly licensed physician and/or surgeon. I understand that this consent will apply only to non-elective medical procedures and that a copy of this form is as valid as the original. However, the Community of the Crucified One, Inc. will not assume financial responsibility for medical treatment that may be necessary. The parent or legal guardian must be willing to accept financial responsibility for illness or injury at Bible School.

**This consent is to be effective from June 15 – 17, 2010.**

Child's medical condition (please write a brief description including present medications, allergies, last tetanus shot, and special health problems, if any).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

TYPE OF INSURANCE: \_\_\_\_\_ MEDICAL ID: \_\_\_\_\_

\_\_\_\_\_ DATE

\_\_\_\_\_ SIGNATURE OF PARENT OR LEGAL GUARDIAN

**Please return this form to:** Vacation Bible School  
Church of the Crucified One  
20 VT Route 100 South  
Moretown, VT 05660