CROWN OF LIFE
SUMMER VBS

Registration Form

Registration forms should be returned to the church office by mail or email by July 5th.

coladmin@crownoflifehubertus.com

DATE OF REGISTRATION

☐☐ / ☐☐ / ☐☐

PERSONAL INFORMATION

Full Name :

Nickname :

Place Of Birth :

Date of Birth : ☐☐ / ☐☐ / ☐☐

Home Church :

Email :

Age :

Gender : ☐ Male ☐ Female

Last Grade of School Completed:

Parent's Name:

Parent Cell:

Parent's Name:

Parent Cell:

Guardian's Name:

Guardian Cell:

ADDRESS

Present Address :

The City :

Present State :

Zip Code :

Parent or Guardian Signature

Date

THANK YOU , PLEASE CONTINUE

See addittional page for more registration

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Registration Form, Continued

I give permission for my child, _____ to attend the Day Camp at Crown of Life.

In the event of an emergency, I give permission to the holder of this form to consent to any medical treatment or hospitalization deemed wise by a licensed physician or emergency team. I also agree to be liable for any and all costs involved in such emergency treatment.

Be advised that my child has the follow physical ailment, allergies, recent injuries, emotional or behavioral disorders, and / or takes the follow listed medicine:

_____

_____

_____

_____

The parent / guardian of the applicant assumes full responsibility for the applicants health being such that Day Camp activities will in no way aggravate any conditions present if in doubt please seek medical advice.

I understand that there are inherent risks involved in outdoor activities which are beyond Camp Phillip's and the church's control and I agree to personally assume such ricks.

I release from any liability Camp Phillip, the church and staff sponsoring this day camp in the event of any accident en route during or returning from this event.

I give permission for my child to be photographed or video taped for use in Camp Phillip's (or Crown of Life's) promotional or educational efforts.

This signature below affirms that the statement on this form is true and understood:

Parent / Guardian's Signature: _____

Health Insurance Carrier: _____

Policy Number: _____

Date Signed: _____