Our Lady of Guadalupe Parish

VACATION BIBLE CAMP K - 6TH

August 5 - August 9, 2019 ~ 8:30 am - 12 pm

REGISTRATION DEADLINE: June 30, 2019

(One form per child. Child must be 4-yrs of age by July 2019)

PLEASE PRINT: Form **MUST BE COMPLETED** to register your child.

Student: Last Name: _____First Name_____

Address: _____

City _____ Zip _____

Date of Birth: _____

School Attending in the Fall 2019_____ Grade: _____

Mother Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell/Work: _____

Father Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell/Work: _____

Valid email: _____

Tuition Includes: Snacks, Book, T-Shirt per family:

(CHECK WHICH APPLIES)

(☐) 1st Child $60.00

(☐) Each additional Child (SAME FAMILY): $50.00

(☐) After 3rd Child ($180.00 total per family)

T- Shirt size: _☐_ S _☐_ M _☐_ L

MAKE CHECKS PAYABLE TO OLOG Parish– Please return forms and fees to:

Our Lady of Guadalupe Parish Office of Faith Formation, 40374 Fremont Blvd. Fremont, CA 94538 510-651-4966

Amount Due: _____ **Total Paid:** _____ **Total Due**: _____**Credit**☐**Cash**☐**CK#**: ☐

ALL PAYMENTS DUE BY JUNE 30, 2019

(MUST COMPLETE OTHER SIDE)

Our Lady of Guadalupe Parish

Faith Formation Office

HEALTH AUTHORIZATION AND RELEASE FORM

Student's Name: _____

OTHERS AUTHORIZED TO PICK UP CHILD:

Name: _____ Phone: _____

Name: _____ Phone: _____

IN CASE OF EMERGENCY, NOTIFY PERSON OTHER THAN PARENT/GUARDIAN:

Name: _____ Phone: _____

Name: _____ Phone: _____

HEALTH AND MEDICAL INFORMATION

Family Physician: _____ Address: _____

Phone: _____ Medical Plan: _____ Plan Number: _____

Do you authorize the Director of Faith Formation or their authorized representative to authorize medical treatment for your child in an emergency, as considered necessary by the attending physician? Yes___ No ___

State any reasons why you do not want medical care given to your child in an emergency: _____

_____

List all conditions (such as allergies, seizures) for which your child requires ongoing medication and state the type and frequency of medication given: _____

Has your child had difficulty with the following (circle all that apply):

Asthma Fainting Spells Convulsions Diabetes Heart Eyes Ears Nose Throat Lungs

Digestion Special needs Other: _____

List any physical restriction or restriction for any activity on the basis of medical condition: _____

_____

Allergy or reaction to any **MEDICATION OR FOOD**? No _____ Yes: _____

List: _____

State the date of your child's last physical examination: _____

I give consent for any pictures taken of my child's during VBS to be published for OLG purposes only.

Parent Signature:_____ **Date:**_____