



St. Paul's UMC weekly small group ministry for 4th-6th grade students

Dates: Sunday afternoons, 3:00 pm-4:15pm

Registration \$20 (Grants are available upon request: Contact Sandra Cox)

Childs Name: _____
(first Name) (last Name)

Circle the grade you are going into for the next School Year for the Fall of 2011
4th 5th 6th

Your E-mail: _____ Your Phone Number _____

Address: _____

City: _____ State: _____ Zip: _____

T-shirt size (Circle one): Youth M Youth L Youth XL Adult S Adult M Adult L

FAMILY INFORMATION

Parent's Name _____

Parent's Mobile Number _____

E-mail Address _____

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT : _____ **Relationship:** _____

Phone # _____

PAYMENT INFORMATION

Check Enclosed

PHOTO / VIDEO RELEASE

I hereby give permission for my son/daughter to be photographed or videotaped at St Paul's UMC. I realize the photo/video may be published in the bulletin or other church publications. The photo/video may be used for informational, educational or promotional purposes regarding our Children's Ministries program.

Important Note: Names of children will not be published.

Parent Signature: _____ Date: _____

PERMISSION TO TRAVEL OFF SITE

I hereby give permission for my daughter/son to attend the E.D.G.E. off-site events, outings and field trips during the program semester. I understand that I will be provided a detailed list of these trips at the Parent Orientation. I further understand that St. Paul's UMC will not be held liable for any bodily injury incurred during any field trip, event or other E.D.G.E. activity and hereby indemnify and relieve them of any such liability. I authorize the E.D.G. E. Staff of St. Paul's UMC (paid or volunteer) to take any reasonable action designed to help ensure the safety, health and welfare of my child/ward, and absolve the staff of any liability relating to such actions.

Parent Signature: _____ Date: _____

MEDICAL QUESTIONNAIRE

If unable to reach the parent (s) or emergency contact person, please contact:

Name: _____ Phone: _____

Name of Physician: _____

Does your child have any physical, mental, or emotional concerns of which we need to be aware? If yes, please explain:

Is your child diabetic? Yes _____ No _____

Suffer from seizures? Yes _____ No _____

Is your child allergic to any foods or medicines? No _____ Yes _____ If yes, list them.

Does your child have difficulties with any of the following? (If so, please explain)

Asthma ___ ADD ADHD ___ Autism ___ Hyperactivity ___ Eyesight ___

Reading ___ Writing ___ Speaking ___ Hearing ___ Other _____

Please list any medications your child is taking that we should be aware of:

I have read and completed the above information and certify that I have disclosed all medical information regarding my child.

Name _____ Date _____

Parent//Guardian