CLEAR FORM

Our Lady of Good Counsel 2014 VBS SonTreasure Island ~ Registration Form (2 pgs)

Name of child:_____ Birth Date Grade Entering: _____

Street Address:_____ City_____ Zip Code_____

Parent/Guardian Name: _____ Email:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Parent/Guardian Name: _____ Email: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

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Photograph and Video Consent

From time to time, pictures and videos may be taken of the VBS event. We would like to be able to use these photographs and videos for flyers, parish and diocesan publications and the ministry website. Written consent of the child's parent(s)/guardian(s) is required. Names will not be posted unless written authorization is given by parent/guardian, and then only first names will be used. If there are concerns about pictures or videos posted on the website, please contact the ministry coordinator or webmaster, and they will promptly be removed.

I/We the parent(s)/guardian(s) of this child_____(child's name), authorize and give full consent, without limitation or reservation, to Our Lady of Good Counsel, to publish any photograph or video in which the above named student appears while participating in any program associated with OLCG Youth and Family Ministry. There will be no compensation for use of any photograph or video at the time of publication or in the future.

Parent/Guardian Signature:_____ Date:_____

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Authorization for Drop off and Pick Up

IT WILL BE REQUIRED THAT EVERY CHILD BE SIGNED IN AND SIGNED OUT EACH DAY.

If parents/guardians cannot be reached or someone other than parent/guardian will be dropping off/picking up the above named child, the person(s) below is(are) allowed:

Name_____ Relationship to child_____ Ph#_____

Name_____ Relationship to child_____ Ph#_____

Name_____ Relationship to child_____ Ph#_____

Parent/Guardian Signature:_____ Date:_____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name: _____ Relationship to participant: _____

Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of Honolulu , chaperons, or representatives associated with the activity, that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

_____

_____

_____

Signature: _____ Date: _____

□ No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____ Date: _____

□ I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____
Immunizations: Date of last tetanus/diphtheria immunization: _____
Does child have a medically prescribed diet? _____
Does child have any physical limitations? _____
Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? _____
Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, list date and disease or condition: _____
You should be aware of these special medical conditions of my child: _____
_____