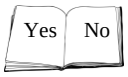
Hillcrest Bible Church VBS (Vacation Bible School) Registration

Ages 5-10 ~ July 24-27, 2023 ~ 6:00-8:00 p.m.

#1 Child _____ Age by July_____

Food Allergies ☐ No ☐ Yes - If "yes", please list:_____

Medical Concerns ☐ No ☐ Yes - If "yes", please explain: _____

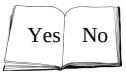


Attended VBS at HBC in 2022

#2 Child _____ Age by July_____

Food Allergies ☐ No ☐ Yes - If "yes", please list:_____

Medical Concerns ☐ No ☐ Yes - If "yes", please explain: _____

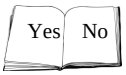


Attended VBS at HBC in 2022

 # 3 Child_____ Age by July_____

Food Allergies ☐ No ☐ Yes - If "yes", please list:_____

Medical Concerns ☐ No ☐ Yes - If "yes", please explain: _____



Attended VBS at HBC in 2022

Parent(s)_____

Email address _____

Cell # _____

Emergency Contact Person_____ Relationship to Student_____

Cell/phone no. _____

Persons with permission to pick up my child(ren):

Name _____ Phone no._____

Name _____ Phone no._____

Guardian Signature:_____ Date: _____

Deadline for Registration – July 16th 2023 - http://www.hillcrestbible.org/ ~ (no charge)

Please place completed forms in box provided on the back counter in the foyer ~ or mail to: Karen Haas - VBS, 14237 SW 116th Terrace - Tigard, OR 97224

HILLCREST BIBLE CHURCH VBS MEDICAL RELEASE FORM

This completed form is required for participation in VBS at Hillcrest Bible Church **UNLESS** a parent or guardian of the enrolled child plans to remain at the church during all 4 of the evening sessions.

4747SW Cameron Rd., Portland, OR (503-887-0512)
July 16th, 2023

Statement of Consent:
In the event of an emergency or non-emergency situation requiring medical treatment, I (print name below), hereby grant permission for any and all medical and/or dental attention to be administered to listed participant(s) until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance and the administration of anesthesia and/or surgery under the recommendation of qualified medical personnel. Please print this form and sign/date your consent below.

Print name _____

Signature: _____

Date: _____

Participants:

_____ _____

_____ _____

PHYSICIAN/ INSURANCE INFORMATION

Physician name, address, phone: _____

_____

Insurance name, phone: _____

Policy holder name: _____

Policy holder relationship to participant(s): _____

Policy ID# _____

Policy Group # _____