Bethlehem Lutheran Vacation Bible School

June 26-30, 2017 9am-noon
18865 SW Johnson Aloha OR 97003
503-649-3380 blcfamily.org
For those entering pre-4 through 6th grade

Student's Name _____M ___ F ___
Birthdate _____
At time of VBS: Age _____ Grade going into fall of 2017_____
Parent/Guardian Name_____
Address _____City_____ State ____ Zip _____
Best # to call:_____Second best# to call: _____
Email Address_____
Home Church _____ City _____
Does your child have allergies or special needs (behavioral or physical) we should know about? *If your child has special dietary needs please bring your own snack each day.* _____
_____
_____

Does your child require or benefit from one-on-one support by use of an aide? ___ yes ___ no
If yes, please explain:_____
Name one friend your child wants to be grouped with: _____
(We can't guarantee this will happen)

IN CASE OF EMERGENCY, PLEASE NOTIFY: Name _____
Best # to call:_____ 2nd best # to call:_____
Relationship to child _____

AUTHORIZED ADULT(S) TO PICK CHILD UP AT VBS:
Name(s) of those picking up my child:_____
Phone Number(s) of Authorized Adults: _____
Relationship(s) to Child:_____

_____ I consent to the use of photographs of my child in publicity, slideshows, & on the web.
_____ I do not consent to the public use of photographs of my child.

I give consent for my child to take part in all VBS activities under supervision, and agree that Bethlehem Lutheran Church will not be held responsible for accidents. I authorize designated and background checked VBS Staff/Bethlehem Lutheran volunteers to provide treatment for my child for injuries and/or illness but they will make an effort to contact me first. I understand that the information on this form may be released to medical personnel in case of medical emergency. I understand that the failure to disclose medical or emotional problems in advance may lead to serious consequences. I verify that everything contained on this form is complete & accurate to the best of my knowledge.

Parent / Guardian Signature _____ Date _____
Family Doctor _____ Phone # _____
Insurance _____ Policy # _____

Registration Fee: By June 1st $13 ____ After June 1st $15 ___