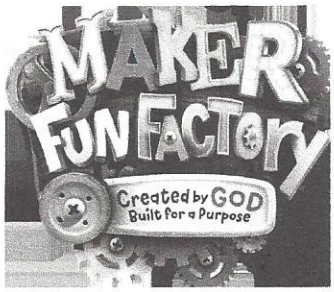

Old First Presbyterian Church
125 Main Street
Huntington, NY 11743

VACATION BIBLE SCHOOL REGISTRATION

Monday, August 21—Friday, August 25, 2017

Date:_____

Last Name: _____

Mother's Name:_____ Member OFC (Y/N)_____

Father's Name: _____ Member OFC (Y/N)_____

Address:_____

Email:_____

Phone: _____(Home) _____(Work/Cell)

_____I would like to help with Vacation Bible School.

	CHILD'S NAME	AGE	GRADE COMPLETED AS OF 6/30 THIS YEAR
1.			
2.			
3.			
4.			
5.			

Registration fees: $10 per child (Maximum $25 for 3 or more children in one family)

Total enclosed:$_____

Please return to the Church Office by August 14, 2017
Spaces are limited. There will be no registration at the door.

Vacation Bible School
Old First Presbyterian Church
Huntington, New York

Participant's Full Name: _____

Full Address: _____

_____

Phone: _____ Date of Birth: _____

Daytime emergency telephone: _____
(if different from above)

PARENT/GUARDIAN PERMISSION

In signing this application, I hereby certify that the information is correct and my son or daughter has my permission to attend the Old First Church activity as stated above, and for the release of medical records in case of illness.

In case of medical emergency, I understand that every effort will be made to contact parents or guardians of participants. In the event that I cannot be reached, I hereby give permission to the physician selected by the advisors to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my son or daughter, as named herein.

Name of family physician or clinic: _____

Telephone: _____

Is participant in general good health and able to participate in all normal actives?
Yes_____ No _____ (If not, please submit a statement indicating limitations.)

Any other important information we shou know about your child: _____

ALLERGIES
(Specify nature of allergic reaction)

____ Animals
____ Food
____ Hay Fever
____ Insect Stings
____ Medicines/drugs
____ Plants
____ Pollen
Other _____
_____

OTHER HEALTH CONDITIONS

____ Convulsions
____ Emotional Disturbances
____ Fainting
____ Hearing impairment
____ Hyperactive
____ Nosebleeds
____ Special; Diet
____ Wears glasses or contact lenses
Other _____

Parents Signature:_____ Date:_____