St. Philip the Apostle Church
Totally Catholic Vacation Bible School

ROAR – Life is Wild, God is Good

VBS Attendee Registration Form

June 17 – 21, 2019
9:30 a.m. – 12:30 p.m.
Ages 3 through Grade 6 (school year 2019-2020)
If you are in Grade 5 (2018-2019) and attended VBS last year, you can register as a Leader in Training (forms are in the Church Undercroft)

Please complete one form per child.
Make checks payable to St. Philip the Apostle

Child's Name_____
Will attend VBS June 17 – June 21, 2019, 9:30 am – 12:30 pm
Cost for week: $15 per child, with $40 maximum per family
There will not be any T-shirts this year. There will be other take home items for the children. Please contact Mary Orite-Shea 513-899-3601 Ext. 207 with any questions.
NOTE: **In order for a child to attend VBS, they need to be able to sit for at least a half an hour listening to a story, watching television, or sitting at the dining table. They must also be potty trained.**

Child's gender: _____ Child's date of birth: _____ Last school grade completed:_____

Name of parent(s): _____
Street address: _____
City: _____ State: _____ Zip: _____

Home telephone: ( )_____ Parent/caregiver's cell phone: ( ) _____

e-mail address: _____

Home parish/church: _____

Allergies/Food Allergies or other medical conditions: _____
In case of emergency, contact: _____
Contact's phone number: _____
Relationship to child: _____

Please complete the Permission, Release and Medical Authorization Form on the back!
Please put form and check made out to St. Philip the Apostle Church in mailbox drawer in the undercroft labeled "Mary Orite-Shea" by May 31, 2019.

OVER →

ARCHDIOCESE OF CINCINNATI PERMISSION, RELEASE AND AUTHORIZATION TO SEEK MEDICAL TREATMENT (rev. 09-2017)

Activity Information: Participate in VBS during VBS June 17 – 21, 2019

1. I, the parent or lawful guardian of _____(the "child"), give permission for my child to participate in the activity described on the Activity Information form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the Activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks.

3. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

4. I appoint the Archbishop or his agents who are acting as leaders of the Activity to seek medical treatment of my child in the event of any injury, illness or medical emergency occurs during the activity or related travel. I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.

5. I [ ] agree [ ] do not agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities.

6. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Authorization to Seek Medical Treatment shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian _____ **Date** ____/____/____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (w) _____ (h) _____

Emergency Contact _____ Phone No. (w) _____ (h) _____

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Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birth date ____/____/_____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Phone No. (h) _____ (w) _____

Member's Birth date ____/____/_____

Family Doctor _____ Doctor's Phone No. _____