



## Vacation Bible School Registration and Waiver Release Form

**Date:** AUGUST 12-16, 2024

**Time:** 9:30 AM – 12:00 PM (except Thursday which is 10 AM-12 PM)

**Location:** HOLY CROSS CATHOLIC CHURCH, 6915 WA-92, LAKE STEVENS

- Please have children arrive by **9:15 AM** for Check-in/Registration

Child's Name (Last, First)	Birthdate	Last Grade Completed

**Parent/Guardian Name(s)** \_\_\_\_\_

**Address** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Parent email address(es)** \_\_\_\_\_

**LIABILITY RELEASE:** In consideration of Holy Cross Catholic Church allowing the above child(ren) to participate in Vacation Bible School activities, I, the undersigned, do hereby release, forever discharge, and agree to hold harmless Holy Cross Catholic Church, its directors, employees, volunteers, and agents (collectively herein the "Church") from any and all liability, claims or demands for accidental personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the above child(ren) while involved in Vacation Bible School. Furthermore, on behalf of my minor child(ren), I hereby assume all risk of accidental personal injury, sickness, death, damage, and expense as a result of participation in activities involved therein. As well as releasing the child(ren), if necessary, for transportation to and from the Vacation Bible School location, I, the undersigned, do hereby release, forever discharge, and agree to hold harmless Holy Cross Catholic Church, its directors, employees, volunteers, and agents from any and all liability, claims or demands for accidental personal injury in the process of transportation.

**MEDICAL TREATMENT PERMISSION:** I authorize an adult, in whose care the minor has been entrusted, to consent to any emergency X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child(ren) pursuant to this authorization.

**PHOTO/VIDEO PERMISSION:** **I DO** (circle one) **I DO NOT** give my consent to Holy Cross Catholic Church to use photo or video images taken of my child(ren) in church brochures, advertisements for the church, on the website, in social media, and in other church publications as they see fit. I agree to hold harmless Holy Cross Catholic Church from any liability that may result from the use of said picture(s). This form will apply throughout my child(ren)'s tenure at Holy Cross Catholic Church's Vacation Bible School. **\*\*None of the photos will be for personal use.\*\***

I hereby give permission for my child(ren) to participate in Vacation Bible School at Holy Cross Catholic Church on August 12-16, 2024 from 9:30 am-12:00 pm each day (except Thursday, which is 10:00 am-12:00 pm).

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Complete one form for up to 3 children in one family.**

**All information will remain confidential to Vacation Bible School staff.**

Child's Name \_\_\_\_\_ Medical Insurance YES\_\_\_ NO\_\_\_  
Insurance Company \_\_\_\_\_ Policy/GroupID# \_\_\_\_\_  
Allergies, Medications, and/or Medical Conditions \_\_\_\_\_  
\_\_\_\_\_  
Activity restrictions \_\_\_\_\_  
Parent/Guardian phone number(s) \_\_\_\_\_  
Emergency Contact: person(s) & phone numbers in case parent/guardian cannot be reached:  
Name \_\_\_\_\_  
Phone \_\_\_\_\_  
People authorized to pick up my child \_\_\_\_\_

Child's Name \_\_\_\_\_ Medical Insurance YES\_\_\_ NO\_\_\_  
Insurance Company \_\_\_\_\_ Policy/GroupID# \_\_\_\_\_  
Allergies, Medications, and/or Medical Conditions \_\_\_\_\_  
\_\_\_\_\_  
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Child's Name \_\_\_\_\_ Medical Insurance YES\_\_\_ NO\_\_\_  
Insurance Company \_\_\_\_\_ Policy/GroupID# \_\_\_\_\_  
Allergies, Medications, and/or Medical Conditions \_\_\_\_\_  
\_\_\_\_\_  
Activity restrictions \_\_\_\_\_  
Parent/Guardian phone number(s) \_\_\_\_\_  
Emergency Contact: person(s) & phone numbers in case parent/guardian cannot be reached:  
Name \_\_\_\_\_  
Phone \_\_\_\_\_  
People authorized to pick up my child \_\_\_\_\_

**Please return all completed Registration/Permission/Waiver forms to:**

LeeAnn Balbirona or Alicia Ramirez in the parish office, open Monday to Thursday 9 AM-4 PM

or scan and email to PAFF@hccclakestevens.org