Emergency Medical Contact, Treatment, and Release of Information Form

Required for VBS

Child's Name: (One form per child) _____

I. Emergency Medical Contact And Treatment

Parent or Guardian _____

Medical Insurance _____ Policy Number _____

Member's Name _____ Phone ( ) _____

Family Doctor_____ Phone ( ) _____

Allergies, other food related information:_____

Medical information:_____

II. Emergency Medical Treatment

In the event of an emergency, the undersigned hereby give(s) permission to transport the Participant to a hospital for emergency medical or surgical treatment. The undersigned wish(es) to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if the undersigned cannot be reached at the above numbers, contact:

Name & relationship: _____ Phone: ( )_____

III. Consent For Release Of Personally Identifiable Information (Leave blank if Consent not granted.)

The undersigned hereby consent to the release of photographs and name of the Participant to be used by the Diocese of Columbus and _____St. Christopher Parish, Grandview_____ (PARISH NAME) for future promotional programs of the Diocese and Parish. If you have any questions or concerns, please contact ____Linda Wolfe, DRE_____(PARISH POINT OF CONTACT) at __(614) 754-8888__ (PHONE NUMBER).

Parent or Guardian Signature _____

Date _____

St Christopher VBS Registration

$40 per child, $25 for sibling (Family of 3 or more, $80)

1) Checks payable to St. Christopher, VBS
2) Return form(s) and payment to Parish office, Linda Wolfe, VBS or mail: 1420 Grandview Ave. Columbus, OH 43212,
3) or, bring form and payment first day of VBS

Contact:
Linda Wolfe
Director of Religious Education
St. Christopher
614-754-8888
lwolfestchris@gmail.com