OXFORD UNIVERSITY
UNITED METHODIST CHURCH

PRESCHOOL VACATION BIBLE SCHOOL REGISTRATION

Child's Full Name: _____

Preferred Name/Nickname: _____ ☐ **Male** ☐ **Female**

Birthdate: _____ **School Attended 2017-2018:** _____

PARENT OR LEGAL GUARDIAN INFORMATION

1. Parent/Legal Guardian Full Name: _____

Relationship to Child: _____ **Cell Phone:** _____
Please list area code first.

Home Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Place of Employment: _____ **Phone:** _____
Please list area code first.

2. Parent/Legal Guardian Full Name: _____

Relationship to Child: _____ **Cell Phone:** _____
Please list area code first.

Home Address: _____ _____ _____ _____
Street *City* *State* *Zip*
(If this address is the same as above, you can leave this section blank.)

Place of Employment: _____ **Phone:** _____
Please list area code first.

EMERGENCY CONTACT INFORMATION

Please provide a cell or other number at which OU personnel are most likely to reach a parent/guardian/emergency contact if your child becomes ill or needs medical attention.

Primary Contact Name: _____

Relationship to Child: _____ **Cell Phone:** _____
Please list area code first.

TWO ADDITIONAL LAFAYETTE COUNTY RESIDENTS TO CONTACT IN CASE OF EMERGENCY:

PLEASE DO NOT LIST FRIENDS OR FAMILY WHO LIVE MORE THAN A 15-MINUTE DRIVE TO OU.

Name: _____ **Relationship to Child:** _____

Cell Phone: _____
Please list area code first.

Name: _____ **Relationship to Child:** _____

Cell Phone: _____
Please list area code first.

FORM CONTINUES ON NEXT PAGE →

OTHER PEOPLE WHO HAVE PERMISSION TO PICK YOUR CHILD UP:

Name: _____ **Relationship to Child:** _____

Cell Phone: _____
Please list area code first.

Name: _____ **Relationship to Child:** _____

Cell Phone: _____
Please list area code first.

POTTY TRAINING

I UNDERSTAND THAT MY CHILD MUST BE COMPLETELY POTTY TRAINED AND INDEPENDENT WITH CLOTHING AND WIPING TO ATTEND PRESCHOOL VBS AND THAT NEITHER DIAPERS NOR PULL-UPS ARE ALLOWED. I UNDERSTAND THAT IF MY CHILD HAS REPEATED ACCIDENTS MY CHILD WILL NOT BE ABLE TO CONTINUE IN VBS.

_____ _____
PARENT(S)/GUARDIAN(S) SIGNATURE DATE

WATER DAY PERMISSION

I GIVE PERMISSION FOR MY CHILD, _____ TO PARTICIPATE IN WATER DAY, HELD THE LAST DAY OF PRESCHOOL VBS. A REMINDER WILL BE SENT HOME PRIOR TO THE EVENT.

_____ _____
PARENT(S)/GUARDIAN(S) SIGNATURE DATE

PHOTOGRAPHY PERMISSION

I GIVE PERMISSION FOR MY CHILD, _____ TO BE PHOTOGRAPHED AND/OR VIDEOTAPED. I UNDERSTAND THAT THESE PICTURES/VIDEOS MAY BE PUBLISHED IN A LOCAL NEWSPAPER, MAGAZINE, ON THE OU WEBSITE, OR ON THE CHURCH'S SOCIAL MEDIA PAGES (FACEBOOK, INSTAGRAM, ETC.)

_____ _____
PARENT(S)/GUARDIAN(S) SIGNATURE DATE

OXFORD UNIVERSITY
UNITED METHODIST CHURCH

AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD

Child's Full Name: _____

Age: _____ **Birthdate:** _____ ☐ **Male** ☐ **Female**

PARENTS' OR LEGAL GUARDIAN INFORMATION

1. Parent/Legal Guardian Full Name: _____

Relationship to Child: _____ **Cell Phone:** _____
Please list area code first.

Home Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Place of Employment: _____ **Phone:** _____
Please list area code first.

Is your child insured through this place of employment? ☐ **Yes** ☐ **No**

2. Parent/Legal Guardian Full Name: _____

Relationship to Child: _____ **Cell Phone:** _____
Please list area code first.

Home Address: _____ _____ _____ _____
Street *City* *State* *Zip*
(If this address is the same as above, you can leave this section blank.)

Place of Employment: _____ **Phone:** _____
Please list area code first.

Is your child insured through this place of employment? ☐ **Yes** ☐ **No**

→ ENCLOSE A COPY OF YOUR INSURANCE CARD—FRONT AND BACK! ←

Insurance Company: _____ **Group No:** _____

Child's SSN: _____ - _____ - _____ **Parent's SSN:** _____ - _____ - _____

Emergency Contact *(in the absence of parents/legal guardian, who is the person responsible?)***:**

Name: _____ **Relationship:** _____

Contact Phone: _____

FORM CONTINUES ON NEXT PAGE

MEDICAL INFORMATION

Please describe any physical health issues—including allergies, chronic medical conditions, recent or major surgeries, etc.:

Treatment for allergic reactions:

Medications Currently Taking *(please note name, dosage, and times taken)* **:**

Tetanus *(date of last immunization)*: _____

Family Doctor: _____ **Phone:** _____
Please list area code first.

I (WE) THE PARENT(S) OF THE CHILD NAMED BELOW, HEREBY AUTHORIZE OXFORD UNIVERSITY UNITED METHODIST CHURCH STAFF OR ADULT LEADER TO CONSENT AND AGREE TO ANY MEDICAL, SURGICAL, OR DENTAL CARE OR TREATMENT BY ANY HOSPITAL, EMERGENCY CARE PROVIDER, PHYSICIAN, OR DENTIST FOR:

_____
CHILD'S FULL NAME

_____
PARENT(S)/GUARDIAN(S) SIGNATURE

_____
DATE