

Parent/Guardian Information:

Parents' or Guardian Name(s) and Addresses:

Telephone Numbers:(home)_____ (Cell #1) _____ (Cell#2)_____

E-mail(s): _____ and _____

Parents' Church Membership: _____

Emergency Contact Information:

Should my child become ill or injured during St. Luke's Presbyterian Church's children's programs and the St. Luke's representative is unable to contact me, I hereby give St. Luke's Presbyterian Church permission to contact one or more of the following persons to contact and/or pick up my child during my absence.

Emergency Contact #1 - Name (other than parents): _____ phone: _____

Emergency Contact #2 - Name (other than parents): _____ phone: _____

Who may pick up your child(ren)? _____

If your child is in 2nd-5th grade, do they have your permission to check themselves out of class to come and meet you after Sunday School? _____ First graders must remain in class for parent/guardian pick-up.

In case of an accident or serious illness during St. Luke's Presbyterian Church's children programs, I request that St. Luke's Presbyterian Church contact me. In case of an emergency, I hereby give St. Luke's Presbyterian Church permission for my child(ren) to be transported by Emergency Medical Services to the closest hospital and given the necessary treatment. I understand that I will be responsible for any and all related charges. PLEASE NOTE: No personally identifiable information about your child will be disclosed to any other person and/or organization, except those noted above.

Publicity: I understand that as a participant my child may be photographed or videotaped during normal event, camp, or mission activities and these photos/videos may be used in promotional materials. I give my permission for my child's likeness to be used in such materials.

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

Child Information: Complete for each child birth-5th grade and sign after each child's information (continues on back).

Child 1- Child's Name: _____ Date of Birth: ____/____/____ Grade: _____

1. Does child have any allergies? ____Yes ____No

Medication: (Please list) _____ Environment: (Please list) _____

Food: (Please list) _____ Insects: (Please list) _____

Reactions: _____

Medication taken: _____

***If an inhaler, EpiPen or Benadryl/antihistamine is required while at St. Luke's-- the parent is responsible for supplying the medication with a note from the child's physician in regard to usage/dose and any other pertinent information .*

2. Has your child been diagnosed with any of these conditions and/or a chronic disease? (Please check)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Requires Inhaler (see above) | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Pump <input type="checkbox"/> Pen | <input type="checkbox"/> Sickle Cell/Trait | <input type="checkbox"/> Hearing/Speech Impairment |
| <input type="checkbox"/> Epilepsy and/or Seizure Disorder | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart | | |

Comments:

3. Does your child have any other restrictions? (i.e. Food/Activity)

4. Is there anything special about this child that you would like caregivers/teachers to know?

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

Child 2- Child's Name: _____ Date of Birth: ____/____/____ Grade: _____

1. Does child have any allergies? ____ Yes ____ No

Medication: (Please list) _____ Environment: (Please list) _____

Food: (Please list) _____ Insects: (Please list) _____

Reactions: _____

Medication taken: _____

***If an inhaler, EpiPen or Benadryl/antihistamine is required while at St. Luke's – the parent is responsible for supplying the medication with a note from the child's physician in regard to usage/dose and any other pertinent information .*

2. Has your child been diagnosed with any of these conditions and/or a chronic disease? (Please check)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Requires Inhaler (see above) | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Pump <input type="checkbox"/> Pen | <input type="checkbox"/> Sickle Cell/Trait | <input type="checkbox"/> Hearing/Speech Impairment |
| <input type="checkbox"/> Epilepsy and/or Seizure Disorder | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart | | |

Comments:

3. Does your child have any other restrictions? (i.e. Food/Activity)

4. Is there anything special about this child that you would like caregivers/teachers to know?

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

Child 3- Child's Name: _____ Date of Birth: ____/____/____ Grade: _____

1. Does child have any allergies? ____ Yes ____ No

Medication: (Please list) _____ Environment: (Please list) _____

Food: (Please list) _____ Insects: (Please list) _____

Reactions: _____

Medication taken: _____

***If an inhaler, EpiPen or Benadryl/antihistamine is required while at St. Luke's – the parent is responsible for supplying the medication with a note from the child's physician in regard to usage/dose and any other pertinent information .*

2. Has your child been diagnosed with any of these conditions and/or a chronic disease? (Please check)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Requires Inhaler (see above) | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Pump <input type="checkbox"/> Pen | <input type="checkbox"/> Sickle Cell/Trait | <input type="checkbox"/> Hearing/Speech Impairment |
| <input type="checkbox"/> Epilepsy and/or Seizure Disorder | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart | | |

Comments:

3. Does your child have any other restrictions? (i.e. Food/Activity)

4. Is there anything special about this child that you would like caregivers/teachers to know?

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