

## THE FIRST CHURCH IN WINDSOR – YOUTH GROUP REGISTRATION

Name of Youth: \_\_\_\_\_ M/F \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Baptized: Y / N \_\_\_\_\_  
Address: \_\_\_\_\_  
Town and Zip \_\_\_\_\_ Home Telephone #: \_\_\_\_\_  
Youth Cell Phone #: \_\_\_\_\_ Can the church text you? Y/N \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
(or legal guardian)  
Address: \_\_\_\_\_  
Home # \_\_\_\_\_ Work # : \_\_\_\_\_ Cell #: \_\_\_\_\_  
Email \_\_\_\_\_ Can the church text your cell #? Y/N \_\_\_\_\_

Father's Name: \_\_\_\_\_  
(or legal guardian)  
Address: \_\_\_\_\_  
Home # \_\_\_\_\_ Work # : \_\_\_\_\_ Cell #: \_\_\_\_\_  
Email \_\_\_\_\_ Can the church text your cell #? Y/N \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Who is authorized to pick up your child? 1 \_\_\_\_\_ 2 \_\_\_\_\_

Describe any allergies/conditions that limit your child's participation (use reverse side if needed):  
\_\_\_\_\_

Name of physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

◆ In the event of an emergency, I hereby give permission to my physician, the Pastors and the Minister of Youth and Outreach of the First Church in Windsor to secure medical treatment for my child/children.

◆ Permission is granted to share my child's name, address and phone number in a class list for all members of his/her class. Yes \_\_\_\_\_ No \_\_\_\_\_

◆ The church maintains a web site, and distributes current information through the EDGE. We would like to share pictures of groups of children and their activities. Children will never be identified as individuals. Yes \_\_\_\_\_ No \_\_\_\_\_

◆ Permission is given for my child to attend "First Friday" and church sponsored youth events. Yes \_\_\_\_\_ No \_\_\_\_\_

Signature of parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

FIRST CHURCH MEDICAL HISTORY (Please print)

1. Is your child being treated for any medical problems? Yes No

Comments: \_\_\_\_\_

2. Does your child suffer from motion sickness? Yes No

Comments:

3. Does your child have any history of allergies reactions to:

Medications: Yes No

Comments: \_\_\_\_\_

Insect bites, bee stings, etc. Yes No

Comments: \_\_\_\_\_

Foods Yes No

Comments: \_\_\_\_\_

Other \_\_\_\_\_ Yes No

Comments: \_\_\_\_\_

4. Is your child on medication? Yes No

Comments: \_\_\_\_\_

5. Name of medication and reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that, in the case of a serious illness or accident and in the event school personnel are unable to reach parents, or persons designated by me, the physician or dentist of my choice will be contacted. If non of these persons can be reached, I hereby authorize school personnel to seek whatever medical or dental attention is deemed necessary, wherever it is available. I also authorize the attending physician or dentist to render necessary treatment.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_