

# Children's Program Registration

From August 2010 - August 2011

PROGRAM NAME T.L.B.S. - Tuesday Mornings

Child's Name: \_\_\_\_\_ Birthday \_\_\_\_\_ Age: \_\_\_\_\_ Boy Girl

Child's Name: \_\_\_\_\_ Birthday \_\_\_\_\_ Age: \_\_\_\_\_ Boy Girl

Child's Name: \_\_\_\_\_ Birthday \_\_\_\_\_ Age: \_\_\_\_\_ Boy Girl

Is there someone who your child would like to have in their class? \_\_\_\_\_

We will do our best to accommodate your request, but keep in mind that differences in age, class size, total enrollment and other factors will also be considered. The final decision is made by the coordinator.

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City and Zip: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Family Security Number \_\_\_\_\_

\_\_\_\_\_ I am a member/regular attendee of High Desert Church.

\_\_\_\_\_ I do not attend church regularly

\_\_\_\_\_ I attend \_\_\_\_\_ Church.

- ◆ Please fill out medical/photo/video release on the back of this registration form.
- ◆ If anything changes throughout the year, please let us know.

Special Needs of your Child:

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## OFFICE USE ONLY:

Registration Fee Paid: \_\_\_\_\_ Balance Due: \_\_\_\_\_

Check Number: \_\_\_\_\_ Cash: \_\_\_\_\_

Date: \_\_\_\_\_

All of the programs that we offer for your child have a standard adult to child ratio for your child's safety. For this reason we may be asking you to volunteer occasionally to help us have the safest possible environment for your child. Thank you for your help.

# Authorization of Consent for Emergency Medical Treatment

I/We the parent(s)/guardian(s) of the above named do hereby authorize the person or persons representing the High Desert Church of Victorville, California as agents for the undersigned to consent to any x-rays examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care required but is given to provide authority and power on the part of aforesaid agents to give specific consent to any and all such diagnosis, treatment and hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California. This authorization is to be effective until it is revoked in writing to said agent.

It is understood that parents or guardians are responsible for all costs not covered by church insurance.

**VIDEO/PHOTO** - I understand that during these sessions of TLBS or SMILES my child may be photographed or videotaped. By signing this release form, I am providing permission for my child to have their picture taken, or appear in a video. Pictures and video recordings may be used by the church for promotional materials, bulletin boards or advertisements of HDC sponsored events. This authorization will remain effective until revoked in writing.

A photocopy of this consent is valid and may be used in place of the original.

\_\_\_\_\_  
(Signature of Father, Mother, or Legal Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Father's full name)      Work Phone \_\_\_\_\_      Home Phone \_\_\_\_\_      Cell Phone \_\_\_\_\_

\_\_\_\_\_  
(Mother's full name)      Work Phone \_\_\_\_\_      Home Phone \_\_\_\_\_      Cell Phone \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance company \_\_\_\_\_ Subscriber \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

Specific information/instructions for filing insurance or for medical staff:

\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Medications taken regularly/Allergies/Medical Problems \_\_\_\_\_

\_\_\_\_\_