St. Michael's VBS Medical & Photo Release

Student Information:
Child #1
Full Name: _____
Date of Birth: _____ Sex: _____ PS or Elem_____
Child #2
Full Name: _____
Date of Birth: _____ Sex: _____ PS or Elem_____
Child #3
Full Name: _____
Date of Birth: _____ Sex: _____ PS or Elem_____

Medical Release:
I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Please list allergies, special medical or dietary needs, or other areas of concern. Please specify which child if more than one is included on this form:
_____
_____
_____

Photo Release:
I give permission for _____ to be photographed at VBS. I also understand my child's photograph might be displayed at the church, the church's website or facebook page.

_____ _____
Signature of Parent/Guardian Date