Registration Form for Ministry Programs at Pioneer Baptist Church

MINISTRY PROGRAMS: Check all that apply:

Nursery ☐ Sunday School ☐ Youth ☐ March Break VBS ☐ SLAM ☐ SLAM Junior Leadership ☐

CONTACT INFORMATION: Please complete one form per person:

Child's Name _____ Date of Birth _____

Street Address _____

Town _____ Postal Code _____

1) Parent's Name _____

Email _____ Phone _____

2) Parent's Name _____

Email _____ Phone _____

3) Guardian's Name _____ Phone _____

4) Other individuals who I give permission to pick up my child include: _____

_____

PHOTOGRAPHY: I give permission to photograph my child for the purpose of posting pictures on the Pioneer Baptist Church website or social media. I grant my permission to take photos: Yes ☐ No ☐

MEDICAL INFORMATION:

Emergency Contact _____ Phone: _____

Does your child have severe allergies (bee stings, food, drugs)? Yes ☐ No ☐

Please specify: _____

Does your child carry any medication (antibiotics, Ventolin, Ritalin)? Yes ☐ No ☐

Please specify: _____

Check if your child currently has any of the following medical conditions:

☐ Appendicitis	☐ Epilepsy	☐ Mumps	Date of Last Tetanus Shot
☐ Asthma	☐ Fainting	☐ Sinusitis	_____
☐ Chicken Pox	☐ Hay Fever	☐ Severe Stomach Aches	
☐ Diabetes	☐ Hepatitis	☐ Sinusitis	
☐ Ear Infections	☐ Measles	☐ Tonsillitis	

Other – Please specify: _____

***** DISCLAIMER AND AUTHORIZATION NOTES: Please read carefully and sign below: ***************************

Precautions are taken for the health and safety of your child, but in the event of accident or sickness, Pioneer Baptist Church, its staff, and volunteers are hereby released from any liability. In the event that your child requires special medication, x-rays, or treatment, every attempt will be made to contact the parents/guardians. Emergency personnel will be called should the situation warrant it.

I authorize the administration of any first aid treatment necessary, and in the case of medical emergency, I give my permission to the attending Physician to hospitalize, secure treatment for, and order injection, anaesthesia, or surgery for my child/youth.

Note: Your child/youth must be covered by Ontario Health Insurance or equivalent medical health insurance:

Provincial Health Card Number: _____

Name of Your Family Physician: _____

Your Physician's Phone Number: _____

***** I agree with the above Disclaimer and Authorization Notes ***

Parent/Guardian Sign Here: _____ Date: _____

Please Print Name Clearly: _____ Cost: By Free-will Offering

NOTE: Please drop off your child(ren) for SLAM *no earlier than 6:20 pm* and pick up your child(ren) *promptly at 7:30 pm.*