

**First United Presbyterian Church
Children's Ministry
Family Registration 2007-2008**

FAMILY INFORMATION:

Parent/Guardian Names: _____

Address: _____

Home Phone: _____ E-mail Address: _____

My location in the church during Sunday school: _____

PERSON (S) ALLOWED TO PICKUP CHILD(REN):

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Phone: _____

Name: _____ Phone: _____

MEDICAL INFORMATION:

Health Insurance Co.: _____ Policy #: _____

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Child's Name: _____ Birth date: _____

Child's School: _____ Grade: _____

Physical Limitation: Vision _____ Speech: _____ Hearing: _____ Motor Skills _____

Learning Challenges: _____

Allergies: Environmental _____ Medical _____ Food _____

Is your child taking any medication? No Yes List: _____

Child's Name: _____ Birth date: _____

Child's School: _____ Grade: _____

Physical Limitation: Vision _____ Speech: _____ Hearing: _____ Motor Skills _____

Learning Challenges: _____

Allergies: Environmental _____ Medical _____ Food _____

Is your child taking any medication? No Yes List: _____

Child's Name: _____ Birth date: _____

Child's School: _____ Grade: _____

Physical Limitation: Vision _____ Speech: _____ Hearing: _____ Motor Skills _____

Learning Challenges: _____

Allergies: Environmental _____ Medical _____ Food _____

Is your child taking any medication? No Yes List: _____

Child's Name: _____ Birth date: _____

Child's School: _____ Grade: _____

Physical Limitation: Vision _____ Speech: _____ Hearing: _____ Motor Skills _____

Learning Challenges: _____

Allergies: Environmental _____ Medical _____ Food _____

Is your child taking any medication? No Yes List: _____

I have read all of the above and acknowledge that all of the information is true and correct. In case of an emergency, I understand that every effort will be made to contact the people I requested. I understand that 911 will be contacted first if the situation warrants such action. I give my permission for my child/ren to obtain medical or surgical care from North Colorado Medical Center, physicians or dentists should the need arise.

I understand that all possible effort will be made to contact me before such action is taken. If it is not possible, treatments as deemed necessary by the physicians may be taken. I authorize direct billing to my insurance and am financially responsible for the charges not covered.

Parent/Guardian _____ Date _____