

St. Mark Vacation Bible School

15800 Montrose Ave., Cleveland, Ohio 44111 216-226-7577

REGISTRATION/MEDICAL FORM

June 23-25, 2009

Name _____ Male/Female _____ Nickname _____ Age _____ Grade completed _____

Address _____ City, State, and Zip _____

Home phone # _____ Mom's Name & Cell phone # _____ Dad's Name & Cell phone # _____
(or work phone #) (or work phone #)

Home e-mail address _____ Home Parish _____ T-shirt size (Youth S, M, L; Adult S, M, L, XL)

EMERGENCY CONTACTS (other than parents):

1) _____
Name Phone # Relationship

2) _____
Name Phone # Relationship

Please list any facts concerning your child's medical history-- allergies (including food allergies), medications being taken, any physical impairments, etc.:

In the event that reasonable attempts to contact me have been unsuccessful, I give my consent for treatment necessary by:

Physician _____ Dentist _____

Phone # _____ Phone # _____

If medically necessary, transfer my child to _____ or any hospital accessible. Preferred hospital

Signature of Parent/Guardian completing this form _____ Date _____

***Complete and return to Rectory Office with \$20 Registration fee by June 1st. (Checks can be made payable to St. Mark Church).**

Office use only: Date received _____ Amount paid _____ Cash/check _____