CENTRAL LUTHERAN CHURCH
FAITH INKUBATORS (Grades 6, 7, 8)
2011-2012 REGISTRATION FORM

Please mail or return this form to CLC Office by August 31!

STUDENT'S NAME: _____ GRADE: _____
Last First Middle

STUDENT'S ADDRESS: _____

HOME NUMBER: _____ BIRTHDATE: _____ SCHOOL:_____

PARENTS/GUARDIANS NAME: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

BAPTIZED? YES NO If so, when and where:_____

Is this student taking COMMUNION? YES NO Is this student a MEMBER of Central Lutheran Church? YES NO

Classmates you'd like in your SMALL GROUP: 1. _____ 2._____

Parents, interested in being a GUIDE? YES NO WORSHIP we attend: 6:30 Wednesday 8:30 Sunday 10:00 Sunday

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CONSENT/MEDICAL RELEASE FORM:

I am the parent/legal guardian of the participant, and hereby grant my permission for him/her to participate fully in Central Lutheran Church related trips and activities.

In the event of an emergency, and I cannot be reached, I give permission for the supervising Central Lutheran staff or the available adult leader to sign forms that would ensure the NECESSARY and IMMEDIATE treatment of the participant. I give permission to those administering emergency treatment to do so using those measures deemed necessary. I furthermore absolve those acting on my behalf in this regard from liability as long as there is not gross negligence. (Please attach a clear statement regarding the treatment of your child in the event of an emergency if different that the instructions stated in this paragraph. Sign and date the statement, please.)

Further, I understand that the child-participant cannot use alcohol, tobacco, drugs, firearms, or fireworks at any Central Lutheran sponsored activity, regardless of location. If those rules are broken, I hereby assume transportation costs incurred for immediately returning the student home.

Signature of Parent or Guardian: _____
Name Date

EMERGENCY INFORMATION:

Name and phone numbers of other persons to contact in case of an emergency (if parent/guardian is unavailable to contact).

NAME: _____ HOME PHONE: _____ CELL PHONE: _____

NAME: _____ HOME PHONE: _____ CELL PHONE: _____

PHYSICIAN NAME: _____ PHYSICIAN NUMBER: _____

FAMILY INSURANCE COMPANY: _____ POLICY #: _____

Allergies, physical limitations, pre-existing conditions, medications currently used, other comments:

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