OUR LADY OF THE FIELDS VACATION BIBLE SCHOOL

Office Use Only
Date Rcvd_____
Amt. Rcvd_____
Check #_____Cash___
CC_____
DSC_____

REGISTRATION FORM

August 5-9, 2019

9:30am-12:30pm

**For children in

PK-4, Kindergarten, and incoming 1st graders**

VBS Fee: $50 per child

Deadline is June 30, 2019

Please make checks payable to and submit to:

Our Lady of the Fields VBS

1070 Cecil Ave., S.

Millersville, MD 21108

(To use a credit card, please fill out the attached form and return with registration form)

410-923-6953 faithformation@olfparish.com

Parent or Guardian Name(s):_____

Address:_____

Phone: Day:_____Cell:_____

Email Address:_____

(Confirmation of receipt of registration will be emailed to you)

Child's Name	Date of Birth	Age	Grade in Sept. 2019	Known Allergies

_____ I would like to apply to help with VBS. Please contact me with more information.

(Please indicate: Adult Volunteer_____ or Teen Volunteer aged 11 to 13____ or 14-17___.)

I grant permission for my child(ren) to participate in Our Lady of the Fields Vacation Bible School. I also grant permission that photos of my child(ren) may be taken and placed on public display without identifying the children by name.

_____

Signature of Parent or Guardian Date

Please fill out the Medical Release Form on the back.

OUR LADY OF THE FIELDS
FAITH FORMATION
MEDICAL RELEASE FORM

Event Name: Our Lady of the Fields Vacation Bible School Dates: August 5-9, 2019

I, the undersigned parent or legal guardian of:_____
(a minor), do hereby authorize adult volunteers of Our Lady of the Fields Faith Formation or adult staff members of Our Lady of the Fields to obtain medical care from a licensed physician, hospital, or medical clinic for my child in the event that I cannot be reached. I agree to RELEASE AND HOLD HARMLESS AND INDEMNIFY Our Lady of the Fields Church, any of its ministries or leaders, the Division of Evangelization and Catechesis, the Roman Catholic Bishop of Baltimore and his successors, A Corporate Sole, and all their agents, servants and employees from any liability, claims and causes of action arising out of my child's participation in the program.

(Check one of the following)
____ I am covered by hospitalization and medical insurance under policy:

#_____issued by_____

____ I do not have medical coverage and assume responsibility for the cost of hospitalization and medical care for my child(ren).

Please list any medical information concerning medications, allergies, or dietary restrictions, etc.

Does your child(ren) have any special needs?

NO _____ YES _____ If yes, please explain: _____

_____

Parent/Legal Guardian:_____
Address:_____
Phone: Home_____Work_____Cell_____
E-Mail:_____

In the case of an emergency, and I cannot be reached, please contact:

Name	*Phone*	*Relationship*

_____

Parent/Legal Guardian Signature Date