

St Patrick's Episcopal Church

7121 Muirfield Drive, Dublin, OH 43017

www.pats-dublin.org

Vacation Bible School

2023 Registration Form



Photography Release: I give permission and consent to allow photographs to be taken during Vacation Bible School.. I further give permission and consent that any such photographs may be published and used by St. Patrick's Episcopal Church to illustrate and promote the mission experience. We, St. Patrick's Episcopal Church, will not release any personally identifiable information without prior written consent from you as parent or guardian.

I/We grant permission for video/photos/images that include this youth to be published on the congregation's website, newsletter, bulletin, Facebook page, or other social media outlets and publications.

Parent/Guardian Signature _____ Date _____

Child's Name: _____ **VBS Class** (to be filled out by nurse) _____

Medical Information:

Allergies: ☐ This child has no known allergies OR ☐ This child has the following allergies:

☐ Food ☐ Medicine ☐ Environmental (insect stings, hay fever, etc) ☐ Other _____

This camper does not eat: ☐ Nuts ☐ Meat ☐ Dairy Products ☐ Seafood ☐ Eggs ☐ Wheat/ Gluten ☐

Other _____

Please describe reaction: _____

My child needs an EPI-pen/ inhaler/ glucose. Please bring your child's rescue medication and written dosing instructions to VBS and check in with the nurses station.

We want to be prepared to help your child be most successful here at St. Patrick's VBS!

☐ Does this camper have any special considerations for their learning (ADD, Autism, etc)?

☐ Does this camper have any special considerations for their medical status (asthma, diabetes, immune compromises)?

☐ Should this camper have any restrictions placed upon his/ her activity, or are there any special considerations for his/ her mobility?

Please describe: _____

Medical Release:

In case of medical emergency, I/we understand that every effort will be made to contact the parent or guardian. In event I/we cannot be reached, I/we hereby give permission to the dentist or physician designated by the staff to hospitalize, secure proper treatment and/or to order an injection, anesthesia, or necessary surgery.

Parent/ Guardian Signature _____ Date _____