St Rose Presents

615 Vine Ave, Roseville, CA 95678

Vacation Bible Camp

Student Helper Form

Monday July 17 – July 21, 2017

9:00 am – 12:00 pm

For Ages: 6th Grade – 17 Yrs Old

$5.00 t-shirt Donation: _____

T-Shirt Size: _____

(Adult: Sm, Med, Lg, XL)

Student Name _____ Age: _____

Birth Date: _____ School Grade in the Fall: _____

Parent's Names:_____

Home Address _____

City: _____ Zip: _____ Phone #:_____

Email: _____

I would like to help: __ as a:

Group leader (1st-5th) ___ In preschool ____ In drama ___In art ____ Other: _____

Complete Emergency form on the back ----------→

Mark Your Calendar

Volunteer Work Day

Tuesday July 11 from 10:00 am – 12:30 pm (Pizza provided at 12pm)

Meet your team leader(s) Learn the Songs Find out Expectations Help prepare for Bible Camp

Sunday July 16 from 11:30 am – 1:00 pm Finishing Touches Set Up





Emergency Form

Student Name: _____ Birth date: _____

Address: _____ Telephone: _____

Parent cell or emergency contact number: _____

If I/we cannot be reached, you have my/our permission to contact either of the following persons:

1. Name_____ Number: _____ Relationship: _____
2. Name_____ Number: _____ Relationship: _____

Name of Family Physician: _____ Telephone: _____

Family Health Plan Carrier: _____ Policy No._____

I understand that the Religious Education program does not assume responsibility for payment of a physician. If our physician cannot be reached, a school official may choose a physician. Yes___/ No ___

Authorization of Consent for Treatment of a Minor

In the event of a serious emergency and none of the persons listed on this form can be contacted, I authorize Religious Education officials to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent for any X-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by and rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at a certified hospital.

I hereby agree to bear all costs incurred as result to the foregoing.

_____
Parent's Name (Please Print)

_____ _____
Parent's Signature Date

My child listed above is ALLERGIC to: _____

My child listed above has been diagnosed with the following Medical Condition(s):

_____

_____

*** I choose not to sign the above statement. In the event of an accident or emergency please:

_____

_____

_____ _____ _____
Parent Name (Print) Parent Signature Date