

Activities Registration Form

Fellowship Baptist Church

5607 Wright Ave.

Racine, WI 53406

(262) 633-3206

I give permission for my child, _____

to attend _____

on _____

sponsored by Fellowship Baptist Church.

As parent or legal guardian, I do hereby authorize medical treatment under the direction of any licensed physician of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me by phone at the information listed below.

The undersigned assumes the responsibility for any costs connected with such treatment and hereby releases Fellowship Baptist Church and sponsors of the above mentioned activity from any liability thereafter.

HAVE YOU COMPLETED THE ANNUAL HEALTH FORM?

YES

NO

HAVE THERE BEEN ANY CHANGES TO HEALTH INFO?

YES

NO

IF YES PLEASE CONTACT FELLOWSHIP BAPTIST CHURCH

ALLERGIES: _____

MEDICATIONS: _____

Parent or Legal Guardian Signature:

_____ Date: ____ / ____ / ____